COGNITIVE AND EXPERIENTIAL GROUP COUNSELING FOR UNIVERSITY STUDENTS OF ALCOHOLIC PARENTAGE

by

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DEDICATION

This dissertation is dedicated to all alcoholic families, especially my own: to Dr. Harry F. Klinefelter, Jr., and the late Elaine W. Prosser, my parents; to Stan and Susan, my brother and sister.

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This study examined the relative effectiveness of two types of structured group counseling specifically designed for undergraduate and graduate students with an alcoholic parent. Thirty-three volunteer subjects were randomly assigned to one of two experimental counseling groups (cognitive or experiential) or to a delayed treatment control group. Each group covered the following sequence of identical concepts: alcoholism and treatment, the nonalcoholic spouse, children of alcoholics, healthy coping attitudes and behaviors, and responsible drinking behavior. Treatment consisted of five consecutive, weekly two-hour sessions. The didactic or cognitive group emphasized lectures, films, guest speakers, and discussions, whereas the experiential group participated in site visits, role plays, and expressive drawing.

The cognitive and experiential groups were compared to the control group on the basis of posttests administered immediately following counseling, then again two months later (follow-up data collected from 28 subjects). The dependent variables investigated were knowledge, attitudes, and behavior related to (1) responsible alcohol use and (2) coping with an alcoholic family. The variables were measured by subjects' responses on the corresponding scales of the Student Drinking Information Scale and the Parental Alcoholism Information Survey.

Analysis of covariance revealed no significant differences between the three groups regarding increases in responsible drinking attitudes and responsible drinking behavior. A significant increase (p = .05) by the cognitive group in knowledge about alcohol compared to both the experiential and control groups (post-post only) was the lone significant finding in the area of responsible alcohol use. Both experimental (cognitive and experiential) groups demonstrated a significant increase in knowledge about alcoholism and its family effects (post only). In comparison to the control group, the cognitive group showed a significant increase in healthy coping attitudes (post and post-post), while the experiential group evidenced a rise in healthy coping behaviors (post only).

The discovery of unique strengths appertaining to each of the two experimental treatments suggests the value of employing a blended experiential-cognitive format. Subject feedback indicates a need for

more support/sharing opportunities. Additional implications of the study and recommendations for future research are discussed.

CHAPTER I
INTRODUCTION

> His mother was an alcoholic, but David seemed the model child. At 7, he was cleaning the house, making dinner, doing the laundry, and minding his unruly younger brother. In high school, he was class president; in college, he graduated with the highest honors. Then, having worked hard to get into law school, he inexplicably found the goal an empty one. Depressed, lonely, confused, he sought help. "Finally, a therapist said to me, 'Was either of your parents alcoholic?'" recalls David, 26. "I was flabbergasted. I had always been a good kid, a smart kid. I couldn't make the connection." (Shah & Reese, 1979, p. 82)

Sadly, the successful linkage with appropriate treatment depicted in the above vignette represents the exception to the rule. Unlike many unfortunate others, this young man was twice blessed. First, he was able to sense that something was wrong and seek help voluntarily; secondly, he had the good fortune to encounter a therapist with an awareness of the probable connection between his personal problems and his alcoholic parentage.

It has long been widely acknowledged that children of alcoholics are significantly more likely than other children to become alcoholic themselves (Nylander, 1969); more recent evidence strongly suggests that this group of offspring also runs an increased risk of encountering psychosocial difficulties in later life (Booz, Allen, & Hamilton, 1974; El-Guebaly & Offord, 1977). Although there has recently been a slight upsurge of interest in their plight, this topic has traditionally received scant recognition in

the scientific literature (Woititz, 1978). This lack of attention accounts for these progeny being variously referred to by such terms as "the forgotten children," "a neglected problem," and "the hidden tragedy" (El-Guebaly & Offord, 1977).

Early efforts in research, prevention, and treatment have focused almost exclusively on the socially visible casualties within this group. This suggests that, until quite recently, caregivers have been guided by the gratuitous and implicit belief that the vast numbers of seemingly well-adjusted children of alcoholics had somehow managed to survive their traumatic early environment without suffering any noteworthy adverse effects. This naive, dangerous assumption typifies the denial and ignorance that have characterized members of the helping professions as well as formulators of social policy and practice in this area (Whitfield, 1980). Experts now realize that many children do not overtly demonstrate disturbed behavioral responses in spite of extensive exposure to distorted familial interactions (Triplett & Arneson, 1978). Data-based studies (e.g., Booz et al. 1974; Miller & Jang, 1977) yield evidence in support of the numerous clinical observations which suggest that these easily overlooked and apparently unharmed survivors of parental alcoholism are also in danger of becoming alcoholics and experiencing alcohol-related problems as adults (Black, 1979; Chafetz, 1979; Woititz, 1978).

This study investigated the effectiveness of two educationally based approaches to group counseling specifically designed to address

the special needs of university students with one or more alcoholic parents. These two types of structured groups were evaluated in terms of their impact on the following two sets of dependent variables: (1) knowledge, attitudes, and behavior related to the responsible use of alcohol; and (2) knowledge, attitudes, and behavior relevant to coping with the dilemma of having an alcoholic parent.

Need for the Study

Alcoholism represents one of this country's most serious health hazards. In addition to the roughly 10 million alcoholics, there are an estimated 29 million children of alcoholics who represent the secondary victims of this disease (Chafetz, 1979). This latter, vulnerable population is officially recognized by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) as a high-risk group and a major target of prevention efforts (Hindman, 1975). Experts indicate that between 1/4 and 1/2 of all alcoholics have had an alcoholic parent or close relative (Bosma, 1972; Fox, 1968; Schuckit, 1973), and one study shows that this group is twice as likely to become alcoholic as the children of nonalcoholic parents (Globetti, Note 1). Research findings leave little doubt that the offspring of alcoholics comprise the "largest high risk population for alcoholism identified to date" (Booz et al., 1974, p. 110).

Family systems theorists and practitioners as well as the proponents of social learning theory would undoubtedly concur with the

following unequivocal observation: "If alcoholism is present in their family, children must experience it and suffer its impact" (Booz et al., 1974, pp. 1-2). High in dependency needs and lacking in awareness, their extreme vulnerability makes them susceptible to certain common developmental problems (e.g., Whitfield, 1980); besides the more obvious victims that are easily spotted, there are many "symptomless" children who suffer emotional damage that only becomes visible in later life (Black, 1979). Along with the aforementioned possibility of developing alcoholism, they have an increased likelihood of encountering the following sequelae as adults: chemical dependency, problems relating to others, marital difficulties, and compulsive work habits (Whitfield, 1980). Feelings of guilt, isolation, depression, insecurity, and mistrust are frequently reported (e.g., Chafetz, 1979); recent clinical findings indicate two prevalent themes among young adult survivors of an alcoholic family. These are an inability to trust their own feelings and a fear of not being in control (Shah & Reese, 1979). In short, having an alcoholic parent is an emotionally upsetting experience for youngsters; if the problems created by parental alcoholism are not resolved (regardless of whether or not the symptoms were evident in early years), they will then plague these innocent victims throughout their lives (e.g., Black, 1979; Booz et al., 1974). The need for effective identification, prevention, and treatment is clear.

In spite of recent advances in scientific research that have contributed to a better understanding of this group's needs, available helping resources are insufficient at best. With the notable exceptions of Alateen (in existence since 1957) and Al-Anon (available to adult children of alcoholics) little meaningful attention is being paid to the treatment needs of children of alcoholics (Booz et al., 1974; El-Guebaly & Offord, 1977). Widespread denial and ignorance (of the existence of a problem) among both caregivers and the would-be help recipients (i.e., the progeny of alcoholics) are the most formidable obstacles to successful identification, prevention, and treatment (Whitfield, 1980).

The social stigma attached to alcoholism contributes substantially to the strong denial system surrounding the disease. A genuine lack of information concerning alcoholism and the effects of parental drinking on the family interacts with the denial to render these children unable to identify their problem and consequently, unlikely to voluntarily seek out assistance. This strongly implies that effective prevention programs would be well advised to include a sensitive yet aggressive outreach component in order to facilitate self-identification and subsequent referral for treatment (Hindman, 1975). The population of interest in this study poses a formidable and unique challenge in this respect.

The overwhelming majority of the potential subject pool for this investigation are easily overlooked by virtue of their belonging

to the "symptomless" category. They have developed highly sophisticated denial systems and defense mechanisms that have enabled them to cope with (and survive) the trauma of living with parental alcoholism. The positive aspects of these roles are readily apparent and frequently rewarded; however, regardless of the role adopted and the strengths developed, there will inevitably be some negative concomitants. Children of alcoholics are usually unaware of these deficits at least until later in life, and this contributes significantly to the difficulty they encounter in assuming the role of one who might be in need of help. It seems that weaknesses arising from these childhood coping patterns are rarely acknowledged (much less dealt with), because these offspring possess minimal awareness of the limitations inherent in whatever coping style they have adopted in order to survive the experience of growing up in an alcoholic family (Black, 1979). The complex and subtle dynamics of the problems facing these superficially well-adjusted children accentuate the need for devising imaginative approaches to preventive intervention. There is presently an acknowledged dearth of innovation and research in education and treatment in this field (e.g., Kern, Tippman, & Fortgang, 1977).

Having identified the children of alcoholics as a legitimate target of prevention efforts, it is important to assess existing primary prevention programs in terms of their capacities for addressing the special needs of this population. The material covered in most alcohol education programs focuses on the effects of

drinking. While this approach is undeniably valuable to successful primary prevention efforts, these programs are insufficient for children of alcoholic parentage. This is partially attributable to the fact that most general alcohol education classes present little, if any, information concerning the effects of parental drinking on the family (Woititz, 1979). This strongly suggests that existing primary prevention programs in alcohol education need to be implemented by secondary prevention efforts specially tailored to fit the unique concerns of this high-risk group.

The few treatment programs designed exclusively for children of alcoholics have invariably included a strong educational component. Dr. Janet Woititz (1979), an experienced educator and private practitioner, argues persuasively for the validity of an educationally based approach to secondary prevention. She firmly believes that the problems facing these secondary victims of alcoholism are primarily informational ones; consequently, she maintains that many in this group can be helped easily and dramatically in relatively short periods of time with this approach (NIAAA, 1979). Understanding the effects of parental alcoholism on the family includes both cognitive and emotional elements. In view of the powerful denial system that characterizes this population, it seems logical that an optimally effective secondary prevention program needs to initially emphasize the presentation of information and ideas as a necessary prelude to the future understanding and expression of feelings (Deutsch, DiCicco, & Mills, 1978).

Purpose of the Study

This study examined the effectiveness of a secondary prevention program developed specifically for university students having one or more alcoholic parents. The program, which was offered at the University of Florida Counseling Center during the Spring, 1981, quarter, consists of two different styles of structured group counseling, cognitive and experiential. Each experimental group was compared to the other and with a delayed treatment control group in terms of its effect on (1) the students' attitudes, knowledge, and behavior related to alcohol use; and (2) the students' knowledge, attitudes, and behavior associated with parental alcoholism.

The breadth of focus and goals of this secondary prevention program for students of alcoholic parentage differs substantially from typical alcohol education programs that are aimed at a general population, thereby falling under the heading of primary prevention. The target subpopulation for this study has understandably attracted great attention as a result of its high-risk status for later becoming alcoholic; however, this special group is also vulnerable in terms of its increased susceptibility to a variety of other mental health problems. This means that a secondary prevention program designed to meet the unique needs and concerns of these neglected casualties of parental alcoholism must necessarily adopt a broad approach to the prevention of mental health problems; it must be one which encompasses more than alcohol education. Consistent with this viewpoint is the strong emphasis which this secondary prevention

program places on enabling students to better comprehend their parent's alcoholism and its effects on the family (especially themselves).

Concomitant with a clearer understanding of the family drinking problem is the learning of alternative, healthy ways of coping (responding, reacting, etc.) with the parent's drinking and its effects. This might also be described as the development of optimally healthy strategies for handling situational concerns that invariably confront members of an alcoholic family. There is a second and equally important component to this newly acquired appreciation of the family drinking problem. By examining the strengths and weaknesses of assorted coping styles and strategies commonly employed by children of alcoholics, group participants are enabled to increase their awareness of the impact that growing up with an alcoholic parent has had on the shaping of their personalities. Alert to deficits in coping styles and to potential dangers of encountering certain adjustment problems in adulthood, group members learn alternative behaviors designed to aid their making healthy decisions concerning how to manage these risks.

The promotion of responsible decision making about drinking is an explicit goal of the program. Notwithstanding its critical importance as a target of secondary prevention efforts, it needs to be emphasized that the issue of responsible drinking constitutes but one of many mental health concerns relevant to this subpopulation.

This means that providing participants with an accurate, objective perspective of the dynamics of an alcoholic family and with a versatile arsenal of healthy options for coping with the effects of parental alcoholism are central to the purpose of this secondary prevention program.

Topics covered in the experimental structured groups included facts about alcohol, alcoholism, the family dynamics of alcoholism, effects on the spouse and children, childhood coping styles, and the responsible use of alcohol. The effects of the cognitive and experiential approaches to structured group counseling for children of alcoholics were examined in terms of their ability to positively influence personal drinking attitudes, knowledge, and behavior in the direction of greater responsibility and positively influence the acquisition of knowledge and of healthy attitudes and behavior that relate specifically to coping with the problems of having an alcoholic parent.

This experiment was designed to answer the following questions:

1. Will a cognitive approach to structured (i.e., educationally based group) counseling bring about a positive change as it concerns knowledge, attitudes, and behavior related to the use of alcohol among university students of alcoholic parentage? Will it change knowledge, attitudes, and behavior relevant to the issue of coping with parental alcoholism?

2. Will an experiential approach to structured group counseling bring about a positive change as it concerns knowledge,

attitudes, and behavior related to alcohol use among university students with alcoholic parentage? Will it change knowledge, attitudes, and behavior relevant to the task of coping with parental alcoholism?

3. Will there be a difference between the two experimental counseling groups and the delayed treatment control group within the above areas immediately following the study? Two months later?

4. Will there be a difference between the two experimental counseling groups within the above areas immediately following the study? Two months later?

Rationale for the Study

An assortment of problems afflict the offspring of alcoholics at varying stages of their lives. This means that the particular characteristics and developmental life stage unique to the population selected for this study need to be given careful consideration in formulating an appropriate prevention program. Preventive intervention is maximally effective when aimed at the youngest possible age group most likely to benefit. Therefore, elementary school children are frequently chosen as the ideal target audience. However, this dominant model of preventive intervention (i.e., directed at little children) is not appropriate for use with the population chosen for this investigation.

The roles adopted by these university students, seemingly well adjusted despite an alcoholic parent, evolved as survival mechanisms;

they served the crucial, adaptive function of providing a way of coping with the task of growing up in an alcoholic home (Black, 1979). Consequently, a program is likely to exert optimal impact if it is implemented when these offspring leave the alcoholic family system and their childhood patterns of coping first begin to show signs of outliving some of their earlier usefulness.

The vast majority of the students in this study are living apart from their alcoholic family for the first time. This provides them with the opportunity to cultivate a more objective perspective of their home situation and to consider alternative ways of dealing with the parent's drinking problem. The time is also ripe for trying out new ways of problem solving if old methods have lost some of their former utility. More importantly, however, these students are confronted with the challenging job of adapting to a new and highly stressful environment in which such sensitive and extremely personal matters as interpersonal relationship formation and responsible drinking become significant issues.

The college years (i.e., the time spent by both graduate and undergraduate students in the pursuit of a formal education) are traditionally regarded as a transitional period in a person's life. Most university students are sufficiently mature to begin making important decisions for themselves, but they are still young enough to effect changes in their behavior patterns (Kraft, 1976). Generally acknowledged to be a difficult adjustment time for all students, the

offspring of alcoholics are especially vulnerable to these imposing situational demands. Regardless of whether or not these progeny of alcoholics are experiencing problems adapting to college life, the examination of personal coping styles in terms of their strengths, weaknesses, and present adaptive value serves the purpose of promoting increased self-awareness. If these students are able to make some connection between difficulties in adjusting to the college environment, and possible lingering effects of their alcoholic parentage, then this will serve as an important first step in assisting their undertaking a transitional process leading to improved adjustment. More serious troubles with alcohol abuse and close personal relationships may surface later in life in the form of alcoholism and divorce (Goodwin, Schulsinger, Hermansen, Guze, & Winokur, 1973). Nonetheless, college age (i.e., ranging from the youngest freshman to the oldest graduate student) represents an ideal opportunity for learning about early warning signs to be on the alert for as adults.

An earlier study of offspring of alcoholic parents by Cork (1969) revealed a substantial amount of mistrust of adults among adolescents (between the ages of 10 and 16). This observation furnished some indirect support for this study's intentional focus on an older (i.e., presumably more trusting) population. Although earlier studies in this area offer no bases for exact comparison, the successes achieved by these efforts are an encouraging sign for the present effort (Deutsch, DiCicco, & Mills, 1978; Weir, 1970;

NIAAA, 1979). Also, the continuing effectiveness of Alateen contributes further to the rationale for this program.

Theoretical support comes largely from assumptions derived from family systems theory and ideas concerning social learning. Proponents of the family systems viewpoint contend that certain unhealthy behavior patterns are forced upon children by virtue of their membership in an alcoholic family (Hecht, 1973). Social learning theory regards the family as the primary matrix for the child's education; learning occurs primarily through identification and role playing; it is both conscious and unconscious (Hecht, 1973). The parents, who demonstrate distorted styles of communication and serve as defective role models, exert a powerful influence by virtue of the child's propensity for imitative learning behavior (Burk, 1972). Evidence to support the validity of this process comes with the results of studies which reveal that the drinking patterns of most people closely resemble those of their parents (Chafetz, 1979). By explaining how the early learning of these children was shaped by their alcoholic family background, these theories furnish a solid framework and ample justification for efforts to help these secondary victims to more fully understand the effects of their early upbringing. Such insight can help free them to decide what, if any, changes they wish to make in their manner of behaving.

Definition of Terms

Certain terms and phrases are used frequently in this study, and several are susceptible to a wide range of varying interpretations. Although most have already appeared in the text, they are defined below to provide clarification and to avoid any further ambiguity.

Alcohol Education

An activity or program which provides educational experiences related to alcohol for the purpose of helping the recipients to be able to make responsible decisions related to the use or nonuse of alcohol.

Alcoholic

In general terms, this refers to an individual whose use of alcohol significantly impairs personal, social, or occupational functioning (Ray, 1978). For the specific purposes of this study, the label is used if the student answers "yes" (for one or both parents) to three or more of the questions (see Appendix A) concerning the student's reactions to parental drinking habits.

Alcoholic Family or Home

A family or home in which at least one (step-) parent is an alcoholic according to the specific criteria used in this study.

Children of Alcoholics

In its broadest sense, this includes all infants, children, teenagers, adults, and the elderly who have at least one alcoholic

parent. For the purposes of this study, it refers to members of this population who are volunteer students enrolled at the University of Florida.

Cognitive

Primarily operating through intellectual thought and verbal learning processes.

Experiential

Involving the gestalt composed of the cognitive-affective-sensory-motor learning processes.

Group Counseling

A process of verbal exchange and discussion of attitudes and feelings among individuals within the normal range of adjustment and a counselor. The group's goal is the understanding and modification of feelings and attitudes so that participants are better equipped to deal with developmental concerns and problems.

Healthy Coping Attitudes

The extent to which someone is likely to endorse a group of behaviors associated with optimally effective ways of dealing with the situations brought on by parental alcoholism. These attitudes correspond to predispositions to behave in the indicated manner.

Healthy Coping Behaviors

These are a specific group of activities generally acknowledged to correlate directly with optimally effective reactions to parental alcoholism.

Negative Behavioral Consequences

A specific group of events that are a direct result of drinking alcoholic beverages, and that increase the chances of problems or complications arising in the drinker's life.

Primary Prevention

Educational efforts aimed at a general audience and applied for the purpose of preventing or minimizing the occurrence of new cases of alcohol abuse in a community.

Responsible Attitudes Toward Drinking

The extent to which an individual is likely to endorse a group of behaviors which is inversely correlated with the frequency of negative behavioral consequences that a drinker might experience.

Secondary Prevention

The application of prevention techniques to a specific, identifiable high-risk group within the community. In this study, university students with one or more alcoholic parent comprise the designated recipients of this specialized type of prevention.

Structured Group

A delimited learning experience having predetermined goals and a plan tailored to enable each group participant to attain the predetermined objectives with minimal frustration and maximal capacity to transfer the newly acquired learning to actual life situations (Drum & Knott, 1977). Educational group counseling, educationally based group counseling, and structured group counseling are considered synonymous and used interchangeably throughout this study.

Subjects

Subjects for this study were students (both undergraduate and graduate) at the University of Florida with one or more alcoholic parents. They were voluntary participants in structured counseling groups. Subject, participant, member, and student are terms that are used interchangeably in referring to these persons unless designated otherwise.

Organization of the Remainder of the Study

This study consists of five chapters. Chapter II presents a review of the literature related to prevention for children of alcoholics, while Chapter III discusses the methodology and data collection. Chapter IV includes a detailed presentation and listing of this study's findings. Chapter V discusses the investigation and offers recommendations for further research in addition to a summary and conclusions. Limitations of the study are also mentioned in the final chapter.

CHAPTER II
REVIEW OF THE LITERATURE

Alcoholism is this country's third most serious health problem; in terms of the total number of people affected, it may represent our worst national mental health and health problem (Bosma, 1972). The alcoholic is the primary and most obvious victim, but this insidious disease also profoundly affects the lives of others with whom the alcoholic comes in contact. Foremost among these secondary casualties are the alcoholic's immediate family members, with children being the most vulnerable of all (Chafetz, 1979).

Although the status of these indirect victims appears to be gradually receiving an increasing amount of attention in the scientific literature, there remains much room for improvement in the areas of research, prevention, and treatment (e.g., Hindman, 1975; Whitfield, 1980; Wilson & Orford, 1978). To appreciate the genuine shortage of material dealing with the effects of alcoholism on the family, consider the following finding from Gail Milgram's 1975 bibliography of Alcohol Education materials: Of the 873 references cited, only 38 relate to the effects on the family; most of these 38 are pamphlets provided by the Al-Anon Family groups. These figures clearly reflect the minimal interest in this aspect of alcoholism (Woititz, 1978). It appears that the family of the alcoholic is almost totally ignored (Bosma, 1972).

This chapter is divided into the following major categories: (1) Recent Literature Reviews, (2) The Forgotten Children, (3) Limited Coping Styles, (4) Needs of and Resources for Children of Alcoholics, (5) Longer-Range Effects of Parental Alcoholism, (6) Identifiable Coping Patterns, (7) Early Emotional Damage Related to "Alcoholic Personality," (8) The Lack of Scientific Progress, (9) Inadequate Treatment Resources, (10) Alateen, (11) Experimental Treatment Programs, (12) Family Dynamics of Alcoholism.

Recent Literature Reviews

Despite the appearance of a growing number of studies over the past decade, the literature in this area remains relatively small and methodologically weak. A broad range of dependent variables have been investigated, utilizing a wide variety of methods and samples. This research topic clearly lacks a unifying theoretical or conceptual framework to guide it; one net effect is that the meaningful comparison of findings becomes nearly impossible (Wilson & Orford, 1978). Before closely examining selected articles that possess special significance for this study, a broad overview of the general state of the literature will be provided. Two recent and extensive literature reviews greatly simplify this seemingly enormous undertaking.

The first of these was prompted by the confusing picture that emerged from various contradictory findings. In a review of

studies spanning the past 25 years, El-Guebaly and Offord (1977) found that many of the earlier investigations were concerned with identifying specific childhood problems that are the sequelae of having an alcoholic parent (e.g., enuresis, temper tantrums, hyperactivity, etc.) (Whitfield, 1980); another clearly observable trend was a preoccupation with focusing attention on the casualties among this population. El-Guebaly and Offord (1977) argued in support of the need for more carefully controlled studies using blind data collection and clear operational definitions. They observed that the variables of poverty, family disorganization, and antisocial behavior all occurred together, but the exact nature of the causal links connecting them presented a challenging, intricate, and unresolved mystery.

This same review also pointed out that the literature on the adult psychosocial adjustment of offspring of alcoholics was primarily concerned with trying to determine the relative impact of genetic and environmental influences on subsequent behavior. These efforts had failed to resolve the age-old "nature-nurture" controversy, and most experts agreed that the ultimate answer lay in a combination of genetic and environmental factors (Goodwin, 1973; Schuckit, 1973). El-Guebaly and Offord (1977) concluded their massive review with the observation that "the offspring of alcoholics appear to be at increased risk for the serious

psychosocial illnesses of adulthood" (p. 364). Finally, this article underscored the inadequacy of treatment programs in terms of their ability to service the needs of this group.

These same authors later participated in a comparative behavioral study of 231 children (ages 9 to 11) of 90 psychiatric patients and their spouses. Subjects were placed into three groups, equally divided between men and women alcoholics, schizophrenics, and depressives. The findings revealed that the children of alcoholic mothers were more impaired than the offspring of schizophrenic and depressive mothers (El-Guebaly, Offord, Sullivan, & Lynch, 1978).

The following year marked the appearance of a somewhat similar literature review. Jacob, Favorini, Meisel, and Anderson (1978) introduced their work by citing a consensus that children of alcoholics are a high-risk group in terms of developing alcoholism and a variety of behavioral disturbances in later life. This review differed from the previous one in that it was limited to an examination of studies (over the past 17 years) that focused on the psychosocial status of children of alcoholics. The absence of well-controlled studies was again noted, and the authors concluded with "modest-to-moderate support for the view that children of alcoholics exhibit significant difficulties in psychological, and family functioning" (Jacob et al., 1978, p. 1242).

Two important data-based studies using psychiatrically disturbed controls were included in this 1978 survey of the

literature. Chafetz, Blane, and Hill (1971) compared personal and familial characteristics of two groups of children in a child guidance clinic, concluding that dissimilarities between the two groups were indicative of "distinct and deleterious social consequences to being the child of an alcoholic parent" (p. 232). The second study, by Fine, Yudin, and Holmes (Note 2), showed that the children of alcoholic parents manifested greater pathology than the controls. These findings indicated that parental alcoholism acts as a serious deterrent to healthy personality development in children; furthermore, Fine et al. (Note 2) concluded that the degree of disturbance might be greater than previously suspected.

Jacob and his co-authors heavily criticized the indirect, self-report approach employed in all of these studies. In addition to this attack on the weaknesses of methodological foundation, the reviewers faulted these investigations for being so difficult to interpret. The sweeping indictment of the fundamental assumptions underlying these methods concluded with their being characterized as "questionable at best and untenable at worst" (Jacob et al., 1978, p. 1243).

This brief look at these two recent and important literature reviews provides a comprehensive overview of the state of research in this neglected and small, but growing area of interest. Having established this background, the next six sections closely examine certain articles that lend support and provide the rationale for this study.

The Forgotten Children

Margaret Cork's book, The Forgotten Children (1969), is a landmark in the field because of its sensitive depiction of the plight of these secondary victims of parental alcoholism. It has attracted much needed attention to this group. Cork, a psychologist at the Addiction Research Foundation in Toronto, located 62 sets of former and current alcoholic parents who agreed to take part in her study. A single interview and a questionnaire were used to query a total of 115 children (ages 10 to 16) concerning their family life and how alcoholism had affected them. This biased sample consisted mostly of children from middle- or upper-class families; another noteworthy feature of the sample was that more than 90% of the offspring lived with intact families.

Cork performed a clinical assessment of the extent of "emotional damage" among these 115 adolescent subjects (based on such factors as hostility, trust, depression, and uneasiness with the opposite sex), and she found varying degrees of underlying personality disturbance in all of them. Nearly half (49%) were rated "fairly seriously damaged," while 43% were considered "very seriously damaged"; the remaining 8% were adjudged "slightly damaged" (El-Guebaly & Offord, 1977). Additional major findings revealed that over 90% lacked self-confidence, felt rejected by their parents, and considered their parents' behavior unpredictable (Jacob et al., 1978). In effect, Cork identified a form of rejection synonymous with

neglect. Based on her overall assessment of these children, she concluded that "should any one of them turn to alcohol to meet some of their emotional needs, there is a very real possibility that they will become alcoholic" (Cork quoted in Hindman, 1975, p. 3). This exploratory, descriptive study explicitly revealed how these children had experienced definite psychological and social damage as a consequence of their alcoholic parentage; further, Cork maintained that this early emotional trauma was a substantial predisposing factor in this group's increased vulnerability for later becoming alcoholic. The outstanding strength of this work was the sensitive way it depicted the special needs of this unique and oft-ignored population. By addressing the hitherto infrequently asked question of the consequences of an atypical family situation for psychosocial development, Cork distinguished herself as something of a pioneer in this field.

Unfortunately, Cork's contribution possessed serious limitations as a scholarly work. The results were based on just one interview, and no control group was used. A somewhat less obvious flaw was the absence of any discussion of positive attitudes. Although partially explainable in light of the tendency for negative feelings to be first ventilated, the omission of positive feelings was nonetheless a regrettable and avoidable oversight (Woititz, 1978). Still another detracting feature was the omission of

operational definitions for the criteria used to rate these children (El-Guebaly & Offord, 1977).

Cork's sample population shares some important characteristics with the population selected for investigation in this study. There is considerable overlap among the two samples in terms of socioeconomic background; also, even though the parents of Cork's subjects were present or former alcoholics, their children were not socially visible casualties. Consequently, her work sheds valuable insight into the quality of family life experienced by university students who grew up under similar circumstances.

Limited Coping Styles

Whereas Cork's (1969) results as described above lack generalizability due to the selection of a biased sample, a most important study by Rouse, Waller, and Ewing (1973) avoids that pitfall. Using a random sample of 186 adolescents from the general population in the South, these researchers examined the relationship between the severity of a father's drinking (as perceived by the children), the stress levels of the offspring, and the methods used to relieve depression and anxiety by the children. The rationale for this investigation of the coping styles of children of alcoholics was derived from earlier studies (using a general population) which had demonstrated the importance of parental modeling in determining the defense and coping mechanisms adopted by the children (Swanson, 1961; Thelen, 1967; Weinstock, 1967).

Rouse, Waller, and Ewing (1973) reported more stress and emotional upset together with fewer and less adaptive means of dealing with their anxiety and depression among children with heavy drinking fathers as compared with abstainers. The more isolated nature of the coping activities engaged in by the offspring of heavy drinkers (trying to forget, smoking, and solitary activities) contrasted sharply with the more social approach to coping (talking with others, eating, and church activities) favored by the children of abstainers.

This investigation by Rouse et al. (1973) directed attention to the fact that the offspring of heavy drinkers resorted to qualitatively different (and presumably less desirable) coping styles than those employed by children of abstaining parents. Such isolated ways of coping seriously diminished the likelihood that this group would seek help voluntarily. In light of these findings, the authors hypothesized that these adolescents would need assistance in coping with anxiety generated by the heavy parental drinking.

Rouse et al. (1973) followed the basic line of investigation begun by Cork in that they examined the emotional effects of living with an alcoholic parent. Although similar to Cork's work in that it was data based and relied on interviews, the study by Rouse et al. (1973) was far superior methodologically. Besides implying that these adolescent offspring of alcoholics needed to

learn alternative and more constructive ways of dealing with the heavy parental drinking, the findings strongly suggested that the very nature of their approach to coping might be maladaptive. Rouse et al. (1973) demonstrated a need for further research aimed at exploring the coping styles and needs of this group.

Needs of and Resources for Children of Alcoholics

On the basis of in-depth interviews, Booz, Allen, and Hamilton (1974) carried out an extensive assessment of the needs of and resources for the children of parents adjudged to be alcoholics by social service agencies. This uncontrolled study was prepared for the National Institute on Alcohol Abuse and Alcoholism (NIAAA). It reported on the consequences of parental and community neglect. The findings were similar in many ways to those of Cork (1969), with the most original feature being their review of the resources available to meet these children's needs. Except for Alateen, there was an obvious lack of national and local response to these needs. While it was possible to argue that resources were perhaps adequate to meet the demand, they were deemed incapable of meeting the existing need. This led to an identification of the formidable educational challenge involved in somehow getting the demonstrated need translated into demand. The Booz, Allen, and Hamilton (1974) report discussed the number, characteristics, life experiences, feelings, coping mechanisms, and problems of children of alcoholics. Also,

their concerns and the factors which variably condition the impact of parental alcoholism were identified.

Prior to presenting some of the more relevant major findings, some unique aspects of this sample warrant mentioning. Fifty children of alcoholic parentage were recruited from four Pennsylvania communities considered, in the aggregate, representative of national socioeconomic and cultural patterns. For the most part, the subjects were white and middle class. The majority (60%) of those who volunteered to be interviewed were between 19 and 30 years old; only 26% were under 18. This age factor is noteworthy, because most previous samples had been limited to children under 18. The sample population in this investigation was still nonrandom and biased, but it reflected somewhat different biases (which closely parallel biases operative in this investigation). Whereas previous researchers had drawn their subjects largely from the stereotypic "lower-class" alcoholic population, this one had a distinct "middle-class" flavor to it. Also, this sample is of special interest here, because it was not composed primarily of agency referrals and identified social deviants. Many features of this particular sample made this study an especially valuable source of information regarding what happened to seemingly well-adjusted children of alcoholic parents as they grew up. Cork had shown the way by identifying many of the concerns of those in the 10 to 16 age group; however, until Booz, Allen, and Hamilton's study (1974)

was published, very little was known of the longer-range sequelae of parental alcoholism.

Booz et al. (1974) arrived at an estimate of the number of children affected by a parent's alcoholism by using the Marden and Cahalan methodologies. Based on a national estimate of 14,099,459 alcoholics, they derived a figure of 28,339,914 as an approximation of the total number of children of alcoholics in this country.

The problems most often reported by the subjects were emotional neglect by the parents (64%) and parental conflict (58%). These findings agreed with those of Cork; the same can be said of the discovery that the emotions most commonly expressed by these children about their family situations were resentment and embarrassment. These researchers probed considerably deeper than Cork into the dynamics of how the offspring were affected. Also, due to the higher age level of their sample, Booz et al. (1974) were able to identify certain common problems typically encountered by this population as they grew older.

Rouse et al. (1973) had reported a fundamental difference in the coping behaviors of children of heavy drinkers versus children of abstainers, but their work left many unanswered questions with regard to the exact nature of these coping devices. The Booz, Allen, and Hamilton (1974) report revealed that most offspring of alcoholics develop identifiable coping mechanisms to facilitate their survival; four predominant patterns were identified: "flight,"

"fight," the "perfect child syndrome," and the "super coper syndrome." These methods of adjusting served as indispensable tools in meeting the survival needs of many children, but there were some who were unable to cope with the anxiety and stress that are concomitants of growing up in an alcoholic home.

Those who relied mainly on fight typically exhibited behavioral problems requiring society's attention. Some examples of this are childhood symptoms such as school problems, temper tantrums, and fighting. For the most part, these childhood problems were either outgrown or else they evolved into adult-related difficulties. This study pointed out that those children who did not rely primarily on the fight coping style and who evidenced no signs of childhood disorders, frequently experienced personal problems as young adults. In other words, the effects of alcoholism on the offspring were much more extensive and long lasting than short-term childhood behavioral disturbances.

These interviews supplied a lot of information on the longer-range adverse effects of parental alcoholism. The emotional ill effects frequently manifested themselves in interpersonal relationship difficulties. The majority of the respondent group (64%) reported having problems with the opposite sex, while nearly one-third (32%) had trouble relating to the same sex. If those in the sample under the age of 18 are excluded, then the percentage of all those with inadequate interpersonal relationships rose to the alarmingly high

figure of 87%! Other less commonly reported but more severe effects included alcohol and drug abuse (16%), depression (18%) and suicidal tendencies (12%), repressed emotions (8%), and lack of self-confidence (34%). Also, nearly one-half of those who were married had a spouse with a drinking problem.

Some of those interviewed believed that growing up in an alcoholic home could contribute to high achievement and help build character. However, the interviews disclosed that nearly all of the high achievers had poor personal relationships; some repressed all emotions, while others suffered nervous breakdowns. This prompted the conclusion that, all things considered, there were no unqualified success stories among children of alcoholics! In one way or another, they all lost as a result of the experience. This evidence clearly supported the truth of the following assertion: "Having an alcoholic parent is an emotionally disturbing experience for children. If children do not resolve the problems created by parental alcoholism, they will carry them the rest of their lives" (Booz et al., 1974, p. 73).

Longer-Range Effects of Parental Alcoholism

Miller and Jang (1977) adopted a different approach to investigating the impact of alcoholic parents on the development of their offspring. Their 20-year study combined both longitudinal and retrospective methodology; the sample consisted of 259 children from lower-class multiproblem families in an urban area of San Francisco.

A control group of 112 children whose parents had no official record of alcoholism were compared with 147 children of alcoholic parents. The subjects were extensively interviewed to determine their social adjustment as adults; the dependent variable of adult adjustment was measured by level of self-esteem and degree of adult adaptation.

The age of the subjects ranged from 22 to 41 at the time of testing. The following statistic corroborated previous similar findings: Among the adult offspring of alcoholics, 36% were classified as heavy drinkers vs. 16% of the adult children of non-alcoholic parents (compared with the national average rate of 7-8%). The study was designed to test the validity of a two-part hypothesis.

The first assumption was that alcoholism leads to poor parenting which in turn predisposes the child to a bad socialization experience (mediated by the sex and age of the child). This was confirmed by findings which showed that offspring of alcoholics had greater socialization difficulties than children of nonalcoholics. The second half of this hypothesis stated that the severity and impact of poor parenting affects the child's later adult behavior and self-concept (often manifesting itself in the form of individually destructive coping behavior). Support for this assumption came from the results which indicated that the extent of the negative impact experienced by the child was in direct proportion to the severity of the parental drinking problem. By way of summary, Miller and Jang (1977) declared that although parental alcoholism significantly

increased the chances of the child encountering problems in adulthood, it was not possible to trace a truly predictive course of inter-generational transmission of alcoholism. This longitudinal study is relevant to this writer's investigation, because Miller and Jang (1977) provided further evidence to support the position that children of alcoholics are likely to have inordinate difficulty with adult adjustment in comparison with their cohorts from nonalcoholic families.

Identifiable Coping Patterns

Sharon Wegsheider (1978) is a major contributor to a more sophisticated understanding of the effects of parental alcoholism on the offspring. After studying more than 400 families in which alcoholism and other chemical dependency was involved, she identified four common patterns adopted by children with this background; they are: (1) the "family hero," (2) the "scapegoat," (3) the "lost child," and (4) the "family pet." These childhood patterns were described in detail, and the hazards of carrying these early coping styles into adult life were clearly spelled out. There is a definite similarity between these roles and those described previously by Booz, Allen, and Hamilton (1974). For example, the super coper closely resembles Wegsheider's "family hero"; similarly, the scape-goat role is the logical consequence of heavy reliance on the "fight" coping mechanism discussed by Booz et al. (1974); the withdrawal practiced by the lost child represents a "flight" type of response

to the family situation. Finally, Wegsheider's (1978) family pet (immature and fragile) approximates Booz, Allen, and Hamilton's (1974) description of the child who is unable to cope. Although her coping patterns are somewhat analogous to those identified earlier by Booz et al. (1974), Wegsheider's descriptive study has considerably deepened our understanding of the topic. In addition to further delineating the various features of these coping styles, Wegsheider described some serious negative consequences that might occur if these childhood patterns are continued unchanged into adulthood (Whitfield, 1980).

For example, the high-achieving family hero achieves visible success and does what is right. This makes the family proud, but the child is nonetheless left with feelings of inadequacy. Wegsheider contended that, in the absence of help, this individual is apt to become a workaholic, feel responsible for everything, have difficulty handling failure, and marry a dependent person. All of these undesirable outcomes are the logical sequelae of carrying this early (and previously adaptive) coping style on into adult life. Fortunately, outside help can enable the family hero (alias super coper) to relax, be responsible for self, accept failure, and avoid marrying an overly dependent person. Wegsheider's basic, underlying assumption was that these adaptive childhood coping mechanisms are apt to backfire and lead to psychosocial problems in adulthood unless help is secured (Whitfield, 1980).

Early Emotional Damage Related to "Alcoholic Personality"

In a somewhat similar vein, clinical social worker Claudia Black (1979) contended that those children in an alcoholic family who superficially appear to have adjusted satisfactorily are also adversely affected; they are just as much in need of assistance as their counterparts who exhibit highly visible behavioral problems. She maintained that parental alcoholism inflicts emotional damage on the offspring that is often not noticeable from without until several years later. Consequently, she stressed prevention as well as intervention, and she focused attention on the socially less visible majority of children of alcoholics that have traditionally escaped the attention of researchers and caregivers in this field.

Black (1979) employed the dynamics of role patterns as a means of explaining the plight of these offspring of alcoholics. Drawing from Adler's ideas on birth order and from family system approaches, she outlined in detail three role patterns typically adopted by these children either separately or in any combination of the three. They are: (1) the "responsible one," (2) the "adjuster," and (3) the "placater." Assumption of any one of these roles or a combination of them enables the child to maintain a balance or homeostasis (however fragile) within the family system. The various roles create strengths that in turn hide the emotional scars. To outsiders, these vulnerable children may at times appear responsible, adapting, sociable, and bright. This illusory outward

appearance of normalcy further underscores the need to educate people about the negative aspects of these roles; establishing this kind of awareness is a necessary prelude to building belief in and support of the need to direct concern and aid to all children from alcoholic families (Black, 1979).

The workings of family dynamics give rise to these roles, and it is almost inevitable that negative sequelae will appear after these early roles have been transformed into adult patterns. It seems that the maladaptive features of these formerly adaptive roles often go unrecognized until the person has adopted a settled lifestyle. Typical effects that then surface include feelings of depression, meaninglessness, and loneliness; great difficulty in maintaining intimate relationships is also common. Many offspring of alcoholic parentage either become alcoholic and/or marry someone with a serious drinking problem. The complex dynamics of growing up in an alcoholic family are conducive to the development of a highly sophisticated denial system that enables short-term emotional survival at the expense of long-term emotional growth. First, children learn not to express their feelings; then, they learn not to feel at all. This pattern begins at an early age, with denial systems starting to form in children as young as five (Black, 1979).

Black's (1979) objective was to help prevent the emotional and psychological "alcoholic" personality that might feed the physiological predisposition. Her efforts were directed at young children,

and art therapy proved to be a successful vehicle for facilitating the expression of feelings. These children were deemed in need of an ongoing recovery program just as much as the parent. A group approach was advocated, because it provided a place in which the participants did not have to adjust, be responsible, or placate others in order to survive; a group setting furnished these young offspring with the opportunity to experience a corrective emotional experience.

As a further aid to understanding the complicated dynamic which operates, here is a rough profile of "well-adjusted" children of alcoholics. In response to parental drinking, they learn to hold in their feelings at all costs in order to avoid upsetting their parents. They also learn to trust only themselves due to uncertainty as to how their parents will react. Both of these responses are attempts to preserve balance and order within a basically chaotic and inconsistent family system. The "overachiever syndrome" is most common, and it may be best explained in terms of social learning theory coupled with knowledge of family systems. The overachievers desperately want to gain approval; by excelling, they become the family's representative to the outside world. The achievement brings with it a sense of control; unlike interpersonal relationships, an honor has the dual advantage of being easily managed and a visible sign of success. The tremendous need to be in control is viewed as a reaction to the chaos at home (Shah & Reese, 1979).

Having taken an in-depth look at some of the studies on children of alcoholics considered most relevant to this investigation, it is now time to examine some of the existing treatment resources for these indirect victims. However, prior to doing that, consideration of some of the factors that seem to be blocking efforts to achieve significant progress in this area will contribute to a more complete and realistic perspective for evaluating all research, prevention, and treatment attempts.

The Lack of Scientific Progress

The science of understanding and helping the children of alcoholics is still in its infancy. In spite of some significant discoveries concerning the ways in which these offspring have been influenced by parental alcoholism, comparatively little progress has been made in providing appropriate treatment. A study performed at the Massachusetts General Hospital in Boston indicated that children of alcoholic parents, while highly represented at the child psychiatric service, were least likely to obtain treatment owing to the nature of their problem (Chafetz, Blane, & Hill, 1971). More recently, a survey of six health professionals with expertise in this field revealed that less than 5% of these offspring were receiving appropriate treatment (Whitfield, 1980). These disturbing findings have prompted experts to search for some logical explanations.

Identification of these secondary casualties is a necessary prelude to research, prevention, and treatment efforts. The

obstacles to successful identification are many. The social stigma, which continues to surround alcoholism, is the major stumbling block, because it fosters a nearly universal denial and ignorance of the problem. The resultant unhealthy climate exerts a powerful influence on the shaping of social policy and practice in the health care system (Whitfield, 1980). The net result is a vicious, self-perpetuating cycle of nonrecognition of the problem and inappropriate treatment by the majority of caregivers (Whitfield, 1980).

Denial and ignorance pose enormous barriers to the task of identifying this population, because these two factors join forces to effectively minimize the likelihood of these secondary victims ever receiving the benefits of treatment. The fact that alcoholism is known as a "family disease" (e.g., Globetti, Note 1; Keane & Roche, Note 3), bears testimony to this complex, enmeshed process in which denial and ignorance are heavily implicated. Nonalcoholic members of such a family typically behave in ways that "enable" the disease of alcoholism to progress. Prompted by feelings of care, love, and concern, they unwittingly cover up, deny and perpetuate the drinking problem (Sessions, Note 6); in effect, they suffer from "co-alcoholism" and become "co-alcoholics" (Whitfield, 1980).

Denial and ignorance also operate on the treatment level to sabotage effective efforts by caregivers. Here, the ignorance manifests itself in the form of lack of appropriate training and awareness (Whitfield, 1980). The problem is serious enough for

Sharon Wegsheider to have coined the term, "the professional enabler" (quoted in Whitfield, 1980, p. 90). The matter is complicated and worsened by some recent evidence which suggests that alcoholism and chemical dependency may be common in the families of health professionals. Surveys of four medical school classes in two universities showed that a minimum of 37% had a parent or other close family member with alcohol or other drug dependency. An even higher percentage of medical students taking substance abuse electives had the problem in their family of origin (Whitfield, 1980). The implication is that health care providers are likely to encounter difficulty performing the tasks of identification, research, prevention, and treatment as a consequence of their having effectively overcome or denied the problem in their own families (NIAAA, 1979). Having presented this basic overview of a few of the major handicaps to the progress of treatment efforts, it is now time to take inventory of the resources available for treatment.

Inadequate Treatment Resources

Despite the periodic occurrence of articles stressing the need for concerted therapeutic efforts in this area, the fact remains that the resources available to meet the need for services are woefully inadequate. The issue is a tremendously complex one. Caregivers maintain that their programs come close to supplying the existing demand for assistance, but some experts contend that treatment

providers are lax in fulfilling their responsibility for helping translate need into demand (Booz et al., 1974).

There is widespread inertia among agencies in terms of devising new approaches aimed at identifying and meeting the special concerns of this neglected population. Most organizations concerned with alcoholism focus on the primary victim (i.e., the alcoholic); consequently, the children are usually ignored, and their needs remain invisible to the professional treating the alcoholic (Hindman, 1975).

Until recently, the impact of alcoholism has been measured largely in terms of loss of work productivity and of highway deaths. Recognition of children of alcoholics as legitimate casualties of the disease represents a recent, progressive phenomenon. The family approach to the treatment of alcoholism is a new trend that holds much promise for helping the victimized children. (Chafetz, 1979).

The reality is that most helping efforts occur only after the parent is in treatment or the child has demonstrated some sort of acting-out behavior; this means that the vast majority of these secondary casualties totally miss out on treatment opportunities. This fact makes it necessary to consider other ways of reaching these easily overlooked individuals and to offer them help in developing healthier personalities. Not only do existing services need to be expanded, but new ones will have to be created. Imaginative, innovative approaches are called for in order to translate well-intentioned treatment goals into workable programs. Due to the aforementioned

obstacles of social stigma, denial, and ignorance, such attempts must include an aggressive outreach component (NIAAA, 1979).

Alateen

Even though the overall picture is somewhat discouraging (Whitfield, 1980), there have been some notably effective programs which may prove helpful in guiding future attempts. Alateen heads the list. In existence since 1957, this self-help organization represents the primary resource available specifically for children of alcoholics (ages 9 to 22). Most who have attended Alateen meetings for a long time attest to its effectiveness and enormous personal value. This worldwide organization has basically adopted the Alcoholics Anonymous approach and applied it to the offspring. Alcoholism is viewed as a family disease, and the children in Alateen are there to learn how to help themselves, not their alcoholic parents. Emphasis is definitely placed on the child's own behavior and feelings and his/her responsibility for them. Alateen is a peer group with adult sponsorship, usually meeting once a week for an hour. This peer group aims to provide a caring, nonjudgmental atmosphere, to help the child understand alcoholism, and to promote personal growth and stability. Understanding and support from the group, together with a belief in AA's Higher Power concept, are the principle vehicles by which help is rendered. The theory is that, with time, the child's emotional dependency needs will shift from his family to the group, and then eventually disperse

to the Higher Power and the self (Booz et al., 1974). Additionally, Alateen provides extensive educational material, and it operates as a forum for exchanging information.

A recent study examined the relationship of Alateen to the adolescent children of alcoholic parents by looking at three groups of subjects. Group 1 consisted of 25 subjects (aged 12 to 19) who had one or two alcoholic parents and who were not members of Alateen; the second or control group contained a like number of adolescents who did not have an alcoholic parent, while the third group consisted of children who had one or two alcoholic parents and who were members of Alateen. All groups were matched by age, sex, grade level, and father's occupational level. This investigation reported that adolescent children of alcoholic parents often suffered from negative emotional moods, low self-esteem, and poor social adjustment (either with the law or at school); the study also showed that the children belonging to Alateen were better off emotionally than those children who were not members (Hughes, 1977).

Despite its obvious value in helping to meet the needs of those children who decide to join, Alateen's effectiveness is severely limited by several factors. Many potential members are aware of its existence, but they do not regard it as a viable option for them. In addition to being stigmatized by its association with AA, it has been criticized by some as being unsophisticated, juvenile, and overly religious; some children reject Alateen because of a lack of

confidence in their peers' ability to help them with their problem, while others are unprepared or unwilling to accept Alateen's independent, laissez-faire attitude toward the alcoholic (Booz et al., 1974).

One psychiatrist has claimed that it is far easier for him to get alcoholics and their spouses to AA and Al-Anon than it is to get a child to Alateen without strong parental support (most unlikely in light of the strong denial practiced in most alcoholic families) (Whitfield, 1980). In spite of its admittedly limited range of appeal, Alateen remains the single most effective and widely known resource available to children of alcoholics; for all intents and purposes, it is the "only game in town" (Booz et al., 1974, p. 96). Many children, however, require more specialized treatment alternatives to supplement Alateen (Whitfield, 1980).

Experimental Treatment Programs

Individual Counseling to Complement Alcohol Education

Weir (1970) introduced a voluntary counseling program as a complement to an earlier alcohol and alcoholism educational program presented to an entire North Dakota high school consisting of 421 students. When 20% of this original population were found to have a family alcohol problem (father and/or mother), Weir (1970) correctly hypothesized that additional needs of some young people would surface as a result of the educational segment of the program.

Analysis of data for students with a family alcohol problem revealed no change in attitudes toward alcohol and the alcoholic as a result of exposure to the general alcohol education program. This provided further rationale for counseling specifically designed to address the special concerns of offspring of alcoholics.

The counseling program consisted of individual counseling "in relation to the use of alcohol and to an alcohol problem" (Weir, 1970, p. 15). It included 13 students from the family alcohol group and 15 from the remainder of the student population. Each student received an average of 5.5 sessions.

The individual counseling sessions were designed to provide students with support and positive options for coping with the family drinking problem. Along with helping the students learn how to deal with alcoholism as an illness rather than as a moral or criminal matter, the counselor was concerned with developing the self-awareness and understanding of clients. Positive results were observed in the majority of those receiving counseling; noticeable differences included better communication, improved family involvement, feelings of greater self-worth, and the chance to experience personal growth (Weir, 1970).

Weir's exploratory study demonstrated a need for alcohol educators to devise programs specially designed to reach out to assist children of alcoholic parentage.

Mother-and-Child Communication Workshop

Kern et al. (1977) developed an experimental treatment program in the form of a short-term mother-and-child communication workshop. Numerous characteristics that are common among all nonalcoholic family members provided the rationale for this education/prevention effort.

Kern's group consisted of three families (three mothers and eight children); the children ranged in age from 13 to 18 years old. For each of eight weeks, there was a structured two-hour meeting. Relying heavily on action-oriented techniques (e.g., psychodrama) and group processes, the two group leaders primarily sought to clarify and focus conversation in addition to promoting adaptive communication. Modest changes in family interactions were observed, but there were no dramatic results.

In retrospect, Kern et al. (1977) decided that an 8- to 10-week group without parents was needed prior to introducing a workshop format for both together. He viewed this adolescent group as differing from Alateen in that it was conducted by a trained leader and more oriented toward short-term growth; Kern's future plans for the children's group included the eventual integration of Alateen as an adjunct and later as the appropriate long-term treatment.

CASPAR Alcohol Education Program

The Cambridge-Somerville Program for Alcoholism Rehabilitation (CASPAR) Alcohol Education Program for children of alcoholics began

in 1976. It was far more comprehensive and sophisticated than the two earlier exploratory studies discussed above.

This model was developed in Somerville, Massachusetts, a blue-collar city of 85,000 adjoining Boston, where one out of every seven adults was considered alcoholic. Although the program staff never anticipated such a large number of children of alcoholics, the secondary prevention program for them was a natural and inevitable outgrowth of the primary prevention effort. Given this high rate of alcoholism, CASPAR officials responded to the need for developing ways of aiding children from families with alcoholism; further, they saw the necessity of assisting these youngsters early in life, help that would not be contingent upon the alcoholic's first receiving treatment (Deutsch, DiCicco, & Mills, 1978).

The entire CASPAR Alcohol Education Program is based on the belief that a school-based approach to primary prevention represents the key to successful efforts aimed at reaching out to children of alcoholics at an early stage, before difficulties arise and become more difficult to reverse (NIAAA Info. & Feature Service, 1979). Trained teachers are the heart of this prevention network. The goal of CASPAR's primary prevention program is to enable youngsters to make responsible decisions about drinking or abstaining.

CASPAR's secondary prevention program provided prolonged and intensive contact to approximately 140 children over a 2-year period (NIAAA Info. & Feature Service, 1979). The vast majority of them came from homes where neither parent was in treatment, and where the

nonalcoholic parent was denying the problem and not functioning as a source of support and understanding to the child. The program's central objective was the modest but attainable one of helping these children understand what had been the dominant fact of their lives--a parent's alcoholism and its effects on the family. This understanding has both cognitive and emotional elements. Ideally, success requires the attainment of both. However, many of these children may be too guilty or unwilling to either express or examine their feelings; CASPAR's program operated on the assumption that they could still absorb and think about ideas related to family alcoholism regardless of degree of readiness to deal with the emotional aspect. If presented in a coherent manner by someone respected and trusted, this would enable these children to eventually explore, understand, and express these feelings (Deutsch et al., 1978).

CASPAR's primary prevention involved alcohol education throughout grades 3 to 12; most grade levels included ten sessions with the following order of teaching objectives: facts about alcohol, attitudes about alcohol and drinking, decision making in drinking situations, and alcoholism. By limiting the topic of alcoholism to the last three sessions, this made it possible to present images of responsible behavior and to avoid a scare approach. The sequence of topic presentation enabled many of these youngsters to establish a societal norm with which to compare the drinking of their parents (Deutsch et al., 1978).

The teacher was able to create an atmosphere in which talking about the illness of alcoholism became acceptable. Unlike the counselor, who responded to alcoholism as a problem, the teacher could initiate help by presenting alcohol education as a subject. This was especially important, because many of those who might benefit from help were not yet in visible trouble. This educational approach helped overcome some basic obstacles to seeking help such as embarrassment and feelings of betraying the alcoholic parent (Deutsch et al., 1978).

The classroom teachers were taught how to recognize pleas for help from these children. Included in teacher training and related to this identification process were the following five objectives for the subunit on family alcoholism: (1) You are not alone. (2) Your parent's alcoholism is not your fault. (3) Alcoholism is a disease. (4) Alcoholics can and do recover. (5) You need and should get help for yourself. While teachers were the most important identifiers, and the primary sources of referral, CASPAR reached children with family alcoholism in other ways. Foremost among these were structured alcohol education workshops conducted by peer leaders during study halls and after school. All workshop participants were paid to attend, and nearly one-third of them eventually identified themselves as having an alcoholic parent. Of all the secondary school children who were identified as children of alcoholics, roughly two-thirds became involved in intervention

which took place in structured groups composed entirely of children of alcoholics (Deutsch et al., 1978).

These after-school workshops, compacted in age as much as possible, were led by a pair of carefully trained and supervised peer leaders who were themselves from alcoholic families. Groups had 6 to 10 members, and activities included discussions, role plays, expressive drawings, films, and field trips. Among the unique features was the requirement that all members attend an Alateen meeting with another person in the group; also, participants were required to make weekly journal entries (Deutsch et al., 1978).

The sequence of subjects for this group contrasted markedly with the other CASPAR curricula. Instead of ending with alcoholism, the group for children with family alcoholism began with several weeks on alcoholism and ended with a subunit on responsible decision making about drinking. The creators of this program felt that most children of alcoholics, despite their claims to the contrary, would eventually drink at some point in their lives; they would do so with a volatile mixture of feelings including fear, guilt, and fascination. CASPAR officials believed that this potentially dangerous process could be averted only if these children were able to acquire either a new perspective on drinking or strategies that would make abstention a more feasible alternative (Deutsch et al., 1978).

Ideal Treatment Program

A group of twelve health professionals met recently at a NIAAA-sponsored symposium on children of alcoholics held in Washington, D. C. They agreed that treatment did not necessarily need to include a formal therapy program. Instead, they believed it should offer the child a "corrective emotional experience" (NIAAA, 1979, p. 3), provide a supportive environment conducive to change, assist in developing coping skills and furnish education about alcoholism (appropriate to the child's age). These same experts concluded that in order to prevent or minimize the development of alcoholism or other emotional problems, services for children of alcoholics needed to be developed which would (1) make them aware of their potential risk level, (2) help them make informed decisions about how to deal with these risks, (3) alleviate the feelings of guilt and isolation that characterizes this group, and (4) provide ongoing treatment for specific problems they are facing (NIAAA, 1979).

The symposium clearly identified education as an indispensable aspect of treatment. The ignorance component of denial was responsible for the fact that many children of alcoholics were unable ". . . to ask for help, because they don't know what to ask help for" (Woititz quoted in NIAAA, 1979, p. 3). The views expressed by these top authorities in the field make it evident that CASPAR's secondary prevention program fulfills most of their criteria for an "ideal" treatment program.

At first glance, it might appear that the next section (on model alcohol education programs for college students) is erroneously included under the heading for experimental treatment programs. While these alcohol education programs were interested in primary prevention rather than secondary prevention for children of alcoholics, the rationale, methodology, and results are highly relevant to this study.

Model Alcohol Education Programs for College Students

Available evidence strongly suggests that the need exists for alcohol education among college students. There is no other population in the U. S. with a larger proportion of drinkers than this age group (Gallup, 1977). Added to this fact is the statistic that 18 to 20 year olds have the highest proportion of people who have encountered some problem in connection with drinking (Harris & Associates, 1974). A national study of 13 universities revealed that 81% of the students were drinkers, and similar findings were reported by a student survey at the University of Florida (Panken, Gonzalez, & Barger, Note 4). A more recent investigation by Gonzalez (Note 5) looked at alcohol use among students enrolled at four major state universities in Florida; 81% of those surveyed were drinkers, and 13% of these students were classified as "problem drinkers"; the definition of problem drinking was a rather conservative one based on the number of negative consequences experienced as a result of alcohol use.

Even though few students have developed patterns of chronic alcohol abuse, the attitudes and behaviors established during the college years have serious implications for later patterns of abuse (Kraft, 1976). The abusive drinking engaged in by many adolescents does not necessarily imply that adult alcoholism will follow; it is primarily the children of alcoholic parents who are in serious jeopardy as a result of abusive adolescent drinking (Chafetz, 1979). Contrary to the impression created by the media's sensationalistic style of reporting, alcoholism is relatively rare among teenagers; however, established alcohol addicts between 20 and 30 years of age are becoming increasingly common (Ritson, 1975).

Alcohol education is the recent approach to the prevention of alcohol problems (Chafetz, 1979). When the student drinking problem first emerged and attracted attention as a crisis situation, a variety of agencies responded by hurriedly developing educational programs. The value of these early efforts was severely limited by their short-sighted manner of approaching the dilemma. In their haste to come up with solutions, program creators overlooked the necessity of designing individual programs tailored to fit the special needs of specific groups (Engs, 1977). The moral is that effective alcohol prevention programs need to be created specifically for certain audiences rather than based upon some generalized approach (Globetti, 1973).

The 3rd Interim Report of the Education Commission of the States on Responsible Decisions About Alcohol (1975) cited the need for alcohol abuse programs to encourage responsible decision making by students concerning alcohol use or nonuse. Faced with a vast pool of ignorance and a lack of agreement in this country regarding what constitutes healthy or responsible drinking, Gonzalez developed standards of responsibility for college students in their attitudes toward alcohol use. These norms were used to create a scale which was then included in an instrument for assessing the effectiveness of an alcohol education program presented to college students at the University of Florida (Gonzalez, 1978).

A 4-hour alcohol education module was designed to encourage discussion of responsible, alcohol-related standards among college students; this module provided factual information about alcohol, and small groups were used for the discussions. The program's impact was measured in terms of the following dependent variables: (1) level of knowledge about alcohol, (2) responsible attitudes toward drinking, and (3) negative behavioral consequences. The module favorably affected the knowledge and attitude variables, with the changes lasting for at least three months. However, no significant difference was found between the experimental and control groups on the incidence of negative behavioral consequences experienced by each group within three months following treatment.

Gonzalez offered two conceivable explanations for this finding. Perhaps attitudes toward alcohol could be changed in a more

responsible direction without a corresponding modification in behavior. A more optimistic interpretation was that a change in attitudes might just be the first step toward actual changes in behavior that would occur later as the result of follow-up activities allowing the students to practice the desired behaviors.

An additional interesting finding of this study was that, over a three-month period, the level of responsible attitudes began to revert back to the pretreatment level. This observation, coupled with the aforementioned absence of significant differences between the experimental and control groups on the negative consequences variable, influenced Gonzalez's decision to suggest the need for experimental, educational activities to follow up his module.

This left the following unanswered questions: What activities were most likely to enhance responsible decisions about alcohol? In what form should these activities be presented? Another alcohol educator at the University of Florida (Rozelle, 1978) conducted an investigation aimed at answering these very questions. Before presenting the details and results of this study, consider briefly the rationale for this approach.

The stated purpose of the Rozelle (1978) study was to determine the relative effectiveness of an innovative experiential approach and a more traditional cognitive approach to alcohol education. The same indicators of effectiveness put together by Gonzalez (desirable changes in students' knowledge, attitudes, and behavior related to drinking) were used.

Rozelle (1978) believed that the best means of implementing this responsible drinking approach would be within the framework of a small discussion group moderated by a nondirective adult leader (Williams, DiCicco, & Unterberger, 1968), or, better yet, by properly trained peer facilitators (Lawler, 1971; Sorenson & Joffee, 1975). Group discussion, which limited itself strictly to the cognitive domain, was considered likely to prove far less effective than if the knowledge or attitudes acquired vicariously in the classroom setting were actually tested out in a personal or social context. Personal experience was clearly advocated as a powerful and persuasive educational force (Russell, 1969).

A leading figure in the field of alcohol abuse prevention (Chafetz, 1970) had generated great controversy by advocating the serving of alcoholic beverages in a supervised group setting in the classroom. The purpose of this experiential learning is to furnish opportunities for students to practice responsible drinking behavior as contrasted with merely talking about it. For example, enabling students to monitor their own Blood Alcohol Concentration level gives them the chance to familiarize themselves with their subjective and objective reactions; this makes it possible for them to actually learn their limit rather than merely understanding that it is a good idea to do so (Rozelle, 1978).

Rozelle's experiential approach consisted of more than just learning how to drink. It also included learning to be a responsible

host or hostess, learning to deal with a problem drinker or a friend who has drunk too much, and obtaining a deeper understanding of the repercussions of alcohol abuse and alcoholism.

Both the experiential and cognitive small group approaches to alcohol education for college students resulted in significantly higher levels of responsible attitudes and knowledge about alcohol than a control group. No significant differences were discovered among the groups in incidences of negative behavioral consequences immediately following treatment. However, three months later, significantly fewer negative consequences were reported by both the experiential group ($p < .01$) and the cognitive group ($p < .05$). A comparison of group means showed that the experiential group consistently scored higher in responsible attitudes and lower in negative behavioral consequences than the cognitive group (Rozelle, 1978). A somewhat surprising finding was the delayed effect of treatment on drinking behavior. This was explained by the simple fact that it takes time for newly acquired attitudes and knowledge to become internalized and subsequently translated in terms of actions (Rozelle, 1978).

Family Dynamics of Alcoholism

Alcoholism is increasingly recognized as a serious disease that adversely affects all family members and not just the alcoholic (Globetti, Note 1; Keane & Roche, Note 3). One expert has even

referred to this family illness as a "collective neurosis" (Sauer, 1976). Without delving into the evidence supporting a genetic pattern of inheriting alcoholism, it is important to consider the family dynamics of alcoholism that contribute heavily to the environmental influences affecting a child's development. The present state of knowledge makes it possible to explain precisely the etiological factors associated with alcoholism and the other adult psychosocial problems related to living in an alcoholic family as a child. Regardless of the extent to which genetic contributions predispose these offspring to develop difficulties in adulthood, educational counseling aimed at improving awareness of the family dynamics of alcoholism can still serve a valuable preventive function.

To the extent that one acknowledges the validity of environmental forces exerting an influence on a child's future development, then a clear understanding of the family dynamics of alcoholism is a necessary prerequisite of successful prevention (based on educational counseling). Family systems theory and social learning theory are useful tools for understanding the sequelae of growing up in an alcoholic family.

Family Systems Theory

Family systems theorists regard the family as an operational, interdependent system; they believe that "change in the functioning of one family member is automatically followed by a compensatory change in another family member" (Bowen quoted in Black, 1979, p. 24).

The child of an alcoholic family grows up in a system in which the usual relationships between the elements forming the system have broken down. The weakness and disorganization in the family structure caused by the alcoholism trigger compensatory changes or reactions from the children. For example, suppose that the father is an alcoholic and the mother expends most of her energy dealing with her husband's drinking; she does so to the necessary neglect of some of her maternal obligations. The oldest child may be forced into assuming certain aspects of the alcoholic father's role that the father is unable to perform. Also, if the mother cannot secure gratification from her spouse, then one of the children may fill that void by serving as the mother's confidante (Hecht, 1973).

The parental alcoholism affects the family system to such an extent that the child is compelled to assume unusual roles and engage in interactions and relationships within the family as each member seeks to obtain gratification from others (Hecht, 1973). The compensatory reactions elicited by the alcoholism represent necessary accommodations to an inherently unstable system. These roles make it possible for the children to preserve a sense of homeostasis that is vital to survival (Black, 1979).

Children are the most vulnerable family members because of their limited awareness and high dependency needs. Their efforts to meet the needs of their siblings or parents impose heavy demands and stresses that are inappropriate for anyone of their age (Jacob et al., 1978). Equally disastrous in terms of their future emotional

adjustment is that these peculiar role patterns, having evolved as natural and necessary survival responses to the alcoholic family system, are often carried unwittingly into adulthood and into relationships outside the family (Hecht, 1973).

Family systems theory offers an extremely useful framework for understanding alcoholism and its effects on the family; this theory has tremendous potential for helping the alcoholic as well as nonalcoholic family members. Potential benefits resulting from the application of these ideas have yet to remotely approach full realization for two reasons. First, this is still a relatively new area that is not yet widely understood. Secondly, families need to protect themselves by denying the existence of a problem (Whitfield, 1980).

Some progress has already been made in applying the basic principles of family systems theory to educational efforts aimed at assisting family members in their efforts to cope with alcoholism. Drawing heavily on knowledge gleaned from the application of these principles to the alcoholic family, experts have published several books (Hornik, 1974; McCabe, 1978; Seixas, 1979; Woititz, 1979) and articles (Black, 1979; Hecht, 1973; Mueller, 1972; Shah & Reese, 1979; Sessions, Note 6) that serve as excellent treatment resources.

Social Learning Theory

Social learning theory's contributions to an understanding of the effects of parental alcoholism on youngsters can perhaps be

best appreciated by examining what its proponents have to say concerning its role in the etiology of alcoholism. Some experts maintain that the concepts of imitation and identification are necessary though not sufficient causative factors in the development of alcoholism (Chafetz & Demone, 1962).

The family represents the primary means by which learning about social behavior and norms is passed on; to a large extent, the family acts as the matrix of the child's education. As a result of interactions occurring within this unit, children learn by absorbing and observing the family's feelings, attitudes, and ways of relating to others. The child learns chiefly through the process of identification; this learning takes place both consciously and unconsciously, and it encompasses both communication and role playing (Hecht, 1973).

Most studies confirm that youngsters tend to adopt the drinking habits of their parents. Heavy-drinking parents will tend to produce heavy-drinking offspring; moderate drinkers, moderate-drinking children, etc. (Bacon & Jones in Chafetz, 1979). Common sense might suggest that having a parent with a serious drinking problem would act as an excellent deterrent to alcohol abuse by the children. A 1942 study of college students revealed that being aware of a parent's drinking problem had not acted as a deterrent to student drinking; the results showed that "even the actual emotionally significant and ever present 'awful example' had no effect on decreasing drinking. In fact, there was actually a

greater incidence of drinking . . ." (Strauss & Bacon quoted in Platt & Moss, 1977, p. 35).

A fairly safe assumption is that much of the learning among young people takes place through such vicarious means as observational learning. Subsequent performances of acts learned in this manner are called imitation or modeling behavior. According to Bandura (1965), no-trial learning by the observer is a frequent and biologically adaptive behavior in humans. Several studies with children support this view according to which much behavior can be learned and/or later performed solely on the basis of observation (Burk, 1972).

A direct implication is that children of alcoholics are vulnerable to becoming alcoholic in later life as a consequence of their having observed the problem solving and coping behaviors of their parents. These children are susceptible to the effects of having alcoholic parents serve as poor or inadequate models. A noted authority in this field contends that these offspring learn complicated behavior patterns from their parents; these early observational learnings constitute a predetermined sequence of response that may be easily triggered in the child's own adult life when confronted by stress. Having personally witnessed complex patterns of behavior in which adults use alcohol to deal with stress, these youngsters are also subjected to the mass media's portrayal of alcohol as an almost indispensable concomitant of adult social

life. Consequently, the young child is conditioned to conclude that excessive alcohol use serves as both a reducer of anxiety and a social stiumlant. This early observational learning sets the stage for the future practice of analagous behavior by the grown child (Burk, 1972).

When stating the case for the social learning theory view regarding the etiology of alcoholism, Burk (1972) contended that these important social factors were highly likely to reinforce and pattern the child in the direction of excessive alcohol intake. The fact that many children of alcoholics somehow manage to develop healthy adult attitudes toward alcohol suggests that other (as yet unidentified) factors intervene and short-circuit this unhealthy process. With this in mind, Burk (1972) suggested that an optimal strategy for reducing the problem of alcoholism in the next generation would be to provide children of alcoholics with the chance to observe mature, well-respected models demonstrating healthy attitudes and behavior toward alcohol.

It would be a naive and serious mistake to leave the impression that a child's attitudes toward alcohol are influenced solely by his own family experience of alcohol use. These attitudes develop out of a complex interplay involving such factors as the parents' attitudes and behaviors, the "establishment," the position of school authorities, and the increasing influence of peers and social factors (e.g., advertising). It is probable, however, that children from alcoholic families tend to attach excessive emotional meaning to alcohol as a

result of their seeing it used as a vehicle for coping with stress and as a means of expressing defiance or anger within the home. Alcohol possesses a special and potentially dangerous importance to children from alcoholic homes, because it belongs to the emotional currency of their family life (Ritson, 1975).

Summary and Implications for the Study

This chapter has shown that children of alcoholics are a high-risk group in terms of having an increased incidence of alcoholism and psychosocial problems in adult life. Living with an alcoholic parent is a traumatic experience, and it is a dangerous mistake to assume that seemingly well-adjusted children from an alcoholic home are somehow less likely to become alcoholic or encounter other problems stemming from their alcoholic parentage than their more socially visible counterparts who exhibit acting out behavior as children.

Whereas recent research efforts have contributed greatly to an improved understanding of the needs of this vulnerable group, available treatment resources leave much to be desired. Very few programs have been specifically developed for the purpose of meeting the needs of this population; Alateen is the best known and most successful. The social stigma attached to alcoholism fosters widespread denial and ignorance throughout society as well as among members of an alcoholic family; these factors pose major hurdles to prevention efforts directed at these offspring. Energetic, sensitive,

and imaginative outreach efforts are desperately needed to alert this group of children to potential risks stemming from their family alcohol problem; this must be done in order to ensure that the need for secondary prevention programs becomes translated into a demand for such specialized services.

Alcohol education efforts focusing on primary prevention are indispensable, but it is clear that the unique needs of children from alcoholic families require an additional, specially tailored form of secondary prevention. The complicated and powerful family dynamics of alcoholism are a significant factor predisposing these children to develop difficulties as adults. Understanding parental alcoholism and its effects on the family members needs to be a central focus of any secondary prevention program for these innocent victims. With sufficient awareness of the family problem (including possible ramifications and sequelae), children will be in a position to learn how to personally cope with the alcoholism on a day-to-day basis; also, they will be equipped to make responsible decisions about how to deal with the myriad risk factors confronting them.

Alcohol programs for college students are valuable resources in terms of the methodological approaches and assumptions that have accompanied these prevention efforts. Using the process of extrapolation, successful ideas, approaches, and methodologies can be borrowed, modified, and then applied to the challenge of devising an effective secondary prevention program for university students with one or more alcoholic parents.

This investigation provides an objective evaluation of a comprehensive, innovative secondary prevention program for students at the University of Florida who come from an alcoholic family. The study compares the effectiveness of two approaches to structured counseling. One relies heavily on cognitive small group discussions, while the other is experientially based.

CHAPTER III
METHODOLOGY

The basic question investigated in this study was whether a secondary prevention program developed specifically for university students with an alcoholic parent would have an effect on: (1) the students' attitudes, knowledge and behavior related to drinking; and (2) the students' knowledge, attitudes, and behavior associated with the parental alcoholism. The program consisted of two types of structured group counseling: experiential and cognitive. Each experimental group was compared to the other and with a delayed treatment control group.

Experimental Hypotheses

The research hypotheses were tested immediately following the program and then retested two months later to determine whether certain effects were immediate, delayed or of longer duration. The research hypotheses are stated below in null form:

1A. There will be no differences between students in the experimental and control groups on the Quantity-Frequency Index of alcohol consumption following their participation in educational counseling.

1B. There will be no differences between students in the experiential and cognitive groups on the Quantity-Frequency Index of alcohol consumption following their participation in structured counseling.

2A. There will be no differences between students in the experimental and control groups on knowledge regarding alcohol after participation in structured counseling by members of the experimental groups.

2B. There will be no differences between students in the experiential and cognitive groups on knowledge about alcohol after taking part in educational counseling.

3A. There will be no differences between students in the experimental and control groups on responsible attitudes toward drinking following participation in educational counseling by subjects in the experimental groups.

3B. There will be no differences between students in the experiential and cognitive groups on responsible attitudes toward drinking following participation in structured counseling.

4A. There will be no differences between students in the experimental and control groups on the incidence of negative behavioral consequences experienced by each group after taking part in educational counseling.

4B. There will be no differences between students in the experiential and cognitive groups on the incidence of negative behavioral consequences experienced by each group following structured counseling.

5A. There will be no differences between students in the experimental and control groups on knowledge about alcoholism and

its effects on the family after participation in structured counseling.

5B. There will be no differences between students in the experiential and cognitive groups on knowledge about alcoholism and its effects on the family after participation in educational counseling.

6A. There will be no differences between students in the experimental and control groups on healthy coping attitudes toward parental alcoholism following educational counseling.

6B. There will be no differences between students in the experiential and cognitive groups on healthy coping attitudes toward parental alcoholism following their participation in counseling.

7A. There will be no differences between students in the experimental and control groups on healthy coping behaviors related to parental alcoholism following their participation in structured counseling.

7B. There will be no differences between students in the experiential and cognitive groups on healthy coping behaviors related to parental alcoholism following their participation in counseling.

The Research Design

This study used a longitudinal pretest-posttest control group design to test the 14 stated hypotheses. This design was necessary since each hypothesis was tested at two different times. These

hypotheses were tested immediately after exposure to the structured group counseling program using pretest and posttest data, and again two months later using pretest and post-posttest data.

The pretest-posttest control group design utilized in this study provided the advantage of controlling for all threats to internal validity (Campbell & Stanley, 1963). Factors that might have jeopardized external validity included reactive arrangements and the interaction effects of selection biases and the experimental treatment (Isaac & Michael, 1971). However, it is unlikely that this latter element represented a serious threat to the external validity of this investigation, since random sampling techniques were used in assigning subjects to experimental and control groups. The reactive effect of possible interaction between testing and treatment was controlled in this design by conducting a test of homogeneity of regression prior to consideration of the performance of an analysis of covariance. This means that the reactive effect of experimental procedures was the only conceivable threat to external validity not explicitly controlled by this research design.

The longitudinal pretest-posttest control group research design to be used in this study can be graphically depicted as shown on the following page.

Table 1

Longitudinal Pretest-Posttest Control Group Research Design

Groups	Pretest	Treatment	Posttest	Two months post-posttest
Experiential	01	X1	02	03
Cognitive	04	X2	05	06
Control	07		08	09

Subjects

The experimental subjects in this investigation consisted of male and female undergraduate and graduate students at the University of Florida who volunteered to participate in structured group counseling for students with one or more alcoholic parents (see Appendix A for criteria for alcoholic parent). Groups were offered during Spring quarter, 1981, at the University of Florida Counseling Center. Due to the social stigma attached to alcoholism and the denial that characterizes most members of an alcoholic family, an extensive, carefully planned educational and advertising campaign was initiated during the Fall quarter of 1980, and it was continued during Winter quarter of 1981. Every effort was made to increase student understanding in this area and to promote awareness of a secondary prevention program (the educational counseling groups) available to students with an alcoholic parent. Steps taken to educate students and to publicize the availability of groups at the

Counseling Center included presentation of 15 to 20 lectures by the writer on the topic of children of alcoholics to a variety of undergraduate classes that included ones in introductory psychology, personal growth, and alcohol use and abuse. Moreover, advertisements were placed in the student newspaper to provide information about the groups and what they had to offer; an article explaining the program (i.e., the counseling groups) appeared in the Winter edition of the Student Services publication; advertising also included a few lines in the "Personal" section of the student newspaper. Finally, local media provided other unexpected sources of publicity in the form of a feature story in the city newspaper and mention of the groups by the campus radio station.

Trial groups were led by the author at the Counseling Center during Winter 1981 quarter. Feedback from group participants was actively solicited and given strong consideration in formulating final plans for conducting the groups during the Spring 1981 quarter.

Volunteer students were randomly assigned to either one of the two experimental groups or to the delayed treatment control group. Maximum group membership was set at 15 for each group. For purposes of this study, a minimum of six members was set as an acceptable sample size; this allowed for expected experimental mortality. Random assignment was utilized to insure pre-experimental equality of the three groups. The actual randomization procedure used to assign volunteers to the various treatment groups was carried out within the

limitations imposed by such unavoidable practical considerations as schedule conflicts and subject availability for participation in the delayed treatment control group. The forthcoming report on the demographic data on group members demonstrates that these potentially limiting factors imposed on the assignment process did not appear to sabotage the primary goal of the randomization procedure (i.e., pre-experimental equality of the three groups).

Those students assigned to the delayed treatment control group were provided with the option of receiving one of the experimental treatments on a delayed basis. Finally, since part of the investigation focused on level of alcohol consumption and other variables directly related to alcohol use, only those students who indicated that they drank alcoholic beverages were included in the analysis of that portion of the data.

An initial pool of 38 student volunteers yielded 33 experimental subjects from whom posttest data were available (28 of the 33 study participants responded to the post-posttest questionnaires mailed out two months following completion of the counseling groups). These students were randomly divided into two experimental groups and a delayed treatment control group with the previously mentioned practical considerations operating as the critical factors in the assignment process.

The experiential group contained 11 subjects: five males (45%) and six females (55%). Ages ranged from 18 to 32 with a mean

age of 23.54. Ten of the participants were white (90.9%), and the remaining subject was black. The breakdown according to class revealed nine undergraduate (81.8%) and two graduate students (18.2%). Five of the undergraduates (55.5%) were seniors. The alcoholic parent was the father for ten (91%) of the 11 group members. Six (54.5%) of the alcoholic parents had acknowledged their drinking problem, and five (45.5%) had either belonged to Alcoholics Anonymous (AA) or received treatment at one time or another. Subjects reported living with their alcoholic parent (i.e., after the parent's drinking first became a problem) for anywhere from 4 to 24.5 years, with 12.11 representing the mean.

The cognitive group was comprised of eight students: three males (37.5%) and five females (62.5%). The subjects' ages ranged from 18 to 27, with 23.5 representing the mean age. All participants were white, and the numbers were evenly divided between undergraduate (50%) and graduate students (50%) with four in each. Three of the undergraduates (75%) were seniors. Half of the group members indicated that their father was the alcoholic parent, while two (25%) subjects' alcoholic parent was the mother; another two participants (25%) reported that both parents were alcoholic. One half of the alcoholic parents had acknowledged their drinking problem, and the same fraction had either been a member of AA or received some other form of treatment. The number of years that subjects reported living with their alcoholic parent(s) ranged from 2 to 18 with a mean of 13.5 years.

There were 14 subjects in the delayed treatment control group: 12 females (86%) and two males (14%). Ages ranged from 19 to 37 with the mean age being 24.1. All subjects were white, and six (43%) were graduate students. Three (37.5%) of the eight undergraduates were seniors. Seven (50%) of the subjects indicated that their father was the alcoholic, whereas the mother had the drinking problem in four (29%) cases; the remaining three participants (21%) had both parents who were alcoholic. Over half (56%) of the parents had acknowledged their drinking problem, and 50% had either belonged to AA or received some other form of help. The number of years that the subjects had lived with their alcoholic parent(s) ranged from three to 21 with 11.0 being the mean number of years having lived with the problem.

Experimental Treatment Procedure

Subjects volunteering to participate in structured group counseling for students with a parental drinking problem were randomly assigned to either the cognitive or experiential group or the delayed treatment control group. The experimental groups were designed to provide participants with a better understanding of their parent's alcoholism and its effects on the family. Major subgoals included the promotion of healthy coping attitudes and behaviors toward parental alcoholism and the development of responsible attitudes and behavior toward the use of alcohol.

Each of the two experimental treatment procedures was offered through the University Counseling Center at 311 Little Hall. They were run simultaneously and consisted of five weekly sessions lasting two hours each. All cognitive group meetings were held at Little Hall, while the experiential nature of the other group necessitated periodic short trips into the community. Both experimental treatment groups were led by the writer and based on the facilitative model of teaching (Wittmer & Myrick, 1980). As group leader, the author was supervised by Dr. Milan Kolarik, a licensed counseling psychologist and member of the Counseling Center staff.

Experiential Group

The experiential group consisted of 11 students. They engaged in a variety of activities addressing five major concepts considered essential to helping participants understand and cope more effectively with their parent's alcoholism and its effects on the family. The activities were predominantly experiential, but there was some discussion for planning and feedback purposes. Activities included role-playing exercises and visiting an Al-Anon meeting (there is no Alateen group in Gainesville). Group members were also given the option of choosing one of the following sites to visit and report on: (1) a local detoxification center; (2) the alcohol treatment program at the local Veterans' Administration (VA) hospital; (3) an open (to non-alcoholics) Alcoholics Anonymous (AA) meeting. Expressive drawing was incorporated into the schedule of

group activities. Still another activity involved participation in an alcohol awareness party where alcoholic beverages were consumed (see Appendix M). Due to moral, religious or legal factors, individual drinking and/or participation was entirely optional.

Prospective group members were asked to sign an informed consent form in accordance with the guidelines of the University Committee for the Protection of Human Subjects. A copy of this form appears in Appendix B. Had any group member elected not to participate in any activity, then that student would have been given an optional activity covering the same concept. No students opted out of participating in any scheduled group activity.

A sample outline for the experiential group is shown in Appendix C. The five group sessions (which began the week after pretesting and individual screening interviews) are described below:

Session #1. Alcohol, alcoholism, and treatment. A brief introduction to the format and purpose of the group was followed by warm-up exercises to help participants begin the process of getting acquainted. Students were presented with the option of selecting one of the following sites to visit during the upcoming week: (1) an "open" Alcoholic Anonymous meeting, (2) the alcohol treatment program (in-patient) at the local VA hospital, or (3) a local detoxification center. Literature was distributed to group members to assist them in the acquisition of a deeper understanding of alcohol, alcoholism, and the recovery process.

Session #2. Alcoholism and the spouse. Group participants shared their experiences from last week's site visits, and the leader elicited students' reactions to and feelings about their visits. The leader emphasized the value of group members understanding the special problems and pressures faced by the nonalcoholic spouse; students were requested to visit an Al-Anon meeting during the week in order to expand their awareness of the family dynamics of alcoholism (leader helped arrange transportation and volunteered to accompany anyone to any of the Al-Anon meetings scheduled for that week). Literature relevant to this session's topic was handed out to students.

Session #3. Alcoholism and the children; Childhood coping patterns. Leader processed reactions of group members to last week's visit to Al-Anon meeting. Students role played an Alateen meeting according to official Alateen guidelines. Literature was distributed that dealt with the effects of parental alcoholism on the children; reading materials illustrated how the child's basic needs are neglected in an alcoholic home. A brief presentation by the leader (of some of the roles typically adopted by children in order to survive living with an alcoholic parent) was followed by an expressive drawing experience. Students were given crayons and a sheet of paper and then asked to portray their childhood pattern(s) of coping by means of a drawing.

Session #4. Healthy coping attitudes and behaviors. Group members acted out role-play vignettes designed to elicit discussion

of healthy coping attitudes and behaviors (see Appendix D). Leader supported the process of participant sharing of personal reactions to role plays. Information relating to this topic was passed out at end of session.

Section #5. Responsible behavior toward alcohol; Responsible drinking behavior; Wrap-up. Group members planned and attended a responsible drinking party (see Appendix M). The University Police Department provided a breath analyzer that enabled students to monitor the level of their Blood Alcohol Content (BAC). Students supplied food, drinks (both alcoholic and nonalcoholic), ice, and mixers. Following the party, reactions to the experience were processed by the leader; participants then engaged in role-play vignettes dealing with the topic of responsible drinking behavior (see Appendix E). Attention focused on the drinker's role in enjoying alcoholic beverages at a party without experiencing negative consequences.

After a final processing of members' reactions to and feelings about the entire structured group counseling experience, the Student Drinking and Information Scale and the Parental Alcoholism Information Survey were distributed to students to be filled out and returned within a few days.

The total time allowed for the various field activities was limited to two hours (including any group time spent at Little Hall) in order to coincide with the amount of time allotted for the cognitive group.

Cognitive Group

The cognitive group was comprised of eight students. This experimental group relied heavily on small group discussion of the five major concepts discussed above. Lectures delivered by the writer and guest speakers were used along with films (see Appendix F) as the principal means of introducing discussion topics. Values Clarification (see Appendix G), which asked students to rank a series of drinking situations according to the criterion of responsible behavior, was also used to facilitate discussion. The complete outline for the cognitive group is shown in Appendix H. The five group sessions are described below:

Session #1. Alcohol, alcoholism, and treatment. Facts about alcohol, alcoholism, and recovery were covered in the film, Chalk Talk (see Appendix E and Note 7). These topics were also addressed by a guest speaker from the North Central Florida Community Alcohol Program. A question-and-answer period and group discussion followed the film and lecture. Literature relating to the content of the session was distributed at the end.

Session #2. Alcoholism and the spouse. The film (which portrays life in an alcoholic home with special focus on the spouse), If You Loved Me (see Appendix F and Note 8), was shown. This was followed by a discussion of the special problems and pressures faced by nonalcoholic family members. Al-Anon literature was made available to all participants.

Session #3. Alcoholism and the children; Childhood coping patterns. The film (which depicted the plight of children of an alcoholic father), Soft Is the Heart of a Child (see Appendix F and Note 9) was presented and followed a guest speaker from Al-Anon. The group leader (author) then delivered a mini-lecture on various roles adopted by children in order to survive growing up in an alcoholic family. There was further discussion, and the group ended with the circulation of Alateen literature and handouts on childhood coping patterns and their sequelae.

Session #4. Healthy coping attitudes and behaviors. There was a mini-lecture by the leader on ways of students coping with the present and future stresses arising from their parent's alcoholism. Also, a guest speaker from the University of Florida Counseling Center staff discussed the option of receiving individual counseling (for the purpose of demystifying the process). There was then a time for group discussion and literature on how to cope effectively with an alcoholic parent was distributed.

Session #5. Responsible behavior toward alcohol; Responsible drinking; Wrap-up. The session began with a brief film dealing with alcohol and the issue of responsible drinking, entitled Booze and Yous (see Appendix E and Note 10). A guest speaker from the University of Florida Alcohol Abuse Prevention Program then discussed the following issues: (1) Deciding whether or not to drink in social settings in order to minimize problems created by drinking, (2) The

drinker's role in enjoying alcoholic beverages at a party without experiencing negative consequences. Discussion and values clarification were used by the guest speaker. Literature on alcohol use and responsible drinking was circulated and then the two measurement instruments (SDIS and PAIS) were distributed to all group members to fill out and return within a few days. This last session ended with the sharing of feedback concerning members' reactions to the entire structured group counseling experience.

It is important to mention here that both experimental groups received identical literature at the end of each session. However, the formats and processes used by the two groups to address the same content issues were clearly quite different.

Instrumentation

Two criterion instruments were used to test the research hypotheses. The first is divided into eight sections; it contains scales designed to measure a student's knowledge, attitudes, and behavior in relation to the use of alcohol. Preceding these three scales are sections which collect demographic data and other information contributing to a fuller understanding of the respondent's drinking behavior (including a quantity-frequency index for operationally defining a student's drinking level). This initial instrument concludes with a brief section of questions for non-drinkers. The second instrument was developed solely for use with individuals of alcoholic parentage. It contains three scales measuring knowledge, attitudes, and behavior in connection with

parental alcoholism and its effects on the family. These scales are preceded by a fourth section which collects demographic data. The following chart lists the seven dependent variables and the corresponding instruments used to measure them. Each of these instruments is described in detail below.

Dependent Variables	Measurement Device
1. Knowledge of alcohol use	1. Student Drinking Information Scale (SDIS). Section V
2. Responsible attitudes about drinking	2. SDIS (Section VI)
3. Negative behavioral consequences experienced as a result of drinking	3. SDIS (Section VII)
4. Reported alcohol consumption	4. Quantity-Frequency Index (included in questions 16-20 of Section I of SDIS)
5. Knowledge of alcoholism and its effects on the family	5. Parental Alcoholism Information Survey (PAIS) Section II
6. Healthy attitudes for coping with parental alcoholism	6. PAIS (Section III)
7. Healthy behavior for coping with parental alcoholism	7. PAIS (Section IV)

Student Drinking Information Scale

The Student Drinking Information Scale (SDIS) (see Appendix I) was developed by G. M. Gonzalez, Coordinator of the Alcohol Abuse Prevention Program at the University of Florida. It represents a

revised version of Gonzalez's Student Drinking Questionnaire (Gonzalez, 1978). The SDIS was designed to measure college students' knowledge about alcohol (Section V), attitudes about drinking (Section VI), and negative behavioral consequences experienced as a result of drinking (Section VII). In addition to eliciting more information from the respondent concerning such areas as personal drinking history, situational factors that affect the amount of alcohol consumed, and reasons for drinking, this self-report measure is an improvement over the SDQ by virtue of its inclusion of a quantity-frequency (Q-F) index. The Q-F Index is valuable because it makes it possible to operationally define and categorize the respondent's drinking behavior. The final section of the SDIS queries nondrinkers concerning the factors that have influenced their decision to abstain; additional questions are aimed at acquiring a clearer comprehension of the perceptual vantage point of nondrinking college students. In this study, only data gathered from Sections V, VI, and VII and questions relating to the Q-F Index (questions 16-20) were subjected to statistical analysis.

Knowledge Scale. Section V consists of 12 factual statements designed to tap the respondent's knowledge of alcohol use. Students may answer true, false, or don't know (this last category is intended to discourage guessing). The range of scores is 12-0, and it is computed by simply adding up the total number of correct (true) responses. Examples of the true-false statements are: "A person can

become an alcoholic by just drinking beer," "Drinking coffee or taking a cold shower can be an effective way of sobering up."

Attitude Scale. The scale contained in Section VI, which may also be referred to as the responsibility-irresponsibility scale, was used in Hypotheses 3 and 3A of this study. It consists of 20 statements concerning responsible behavior in relation to alcohol use. Fifteen of these statements are positively expressed and depict responsible behavior.

This Likert-type attitude measurement scale assesses the degree of the respondent's responsible attitudes. In response to each behavior listed, students answer in terms of how likely they are to act in the indicated manner by selecting any of five responses for each item: very likely, likely, somewhat likely, unlikely, or very unlikely. A "very likely" response to one of the 15 statements of responsible behavior receives a score of 5, whereas a "very unlikely" answer would yield a score of 1. Examples of positive statements are: "Set limits on how many drinks you are going to have on a night out or at a party," "respect a person who chooses to abstain from drinking alcohol." Examples of negative statements are: "gulp drinks for the stronger effect that rapid drinking produces," "drink alone from a desire to escape boredom or loneliness." The items representing irresponsible behavior are inversely weighted. The range of scores for this 20-item scale is 100-20, with the higher score indicating greater responsibility.

Negative Consequences Scale. The negative consequences resulting from the use of alcohol were measured by the Negative Consequences scale for use in Hypotheses 4 and 4A of this investigation. This third major scale appears in Section VII. It lists 20 behaviors which are descriptive of specific negative consequences that sometimes occur as a result of the misuse of alcohol. Respondents are requested to indicate how many times they have experienced each consequence as a result of drinking. Examples of these consequences are: "I have had a hangover," "I have drunk while driving."

The response choices are: never, once, twice, three times, four times, or five times or more. The value assigned each response ranges from 0 for "never" to 5 for "five times or more," thereby yielding a theoretical scoring range of 0-100 for this 20-item scale; the higher score indicates greater negative behavioral consequences. The items on this scale as well as those on the knowledge scale originally came from the Student Alcohol Questionnaire (Engs, 1977).

Quantity-Frequency Index. Reported alcohol consumption by the respondents was measured by the Quantity-Frequency (Q-F) Index in Hypotheses 1 and 1A of this study. The Quantity-Frequency Index, which was developed by Strauss and Bacon (1953), estimates the amount of alcohol an individual typically consumes by multiplying the reported amount usually drunk by the reported frequency of drinking over a stated period. The Q-F Index was adapted for use in later research by Persky (1979).

Items 15, 16, 17, 18, 19, and 20 on the SDIS were used to determine a respondent's Q-F Index in this study. The response on item 15 determined whether the response to item 16, 17, 18, or 19 was multiplied times the response to item 20 to compute the Q-F Index. Responses "a" (beer), "b" (wine), "c" (mixed drinks) on item 15 were matched with items 16, 17, and 18, respectively. A response of "d" (straight liquor) was paired with item 19 to calculate the individual's Q-F Index.

Items 16, 17, 18, and 19 indicated the alcoholic beverage preferred by the respondent and the quantity of that beverage consumed by the respondent. The responses for each item were weighted (with increasing values from "a" to "e") in the following manner:

a. Do not drink = 0

b. 1 or less = 1

c. 2 or 3 = 3

d. 4 or 5 = 5

e. 6 or more = 7

This quantity was then multiplied by the respondent's score on item 20 (which determined the frequency of drinking). The frequency score on item 20 was calculated on a per-month basis:

a. once a month or less = 1

b. 2 or 3 times a month = 3

c. once a week = 4

d. 2 times a week = 8

e. 3 times a week = 12

f. 4 or more times a week = 16

The product represented the respondent's Q-F Index.

Reliability. Reliability of the knowledge, attitude, and behavior scales of the SDIS comes from data collected when these scales comprised the SDQ. The attitude and behavior sections of the SDIS are identical to those in the SDQ; however, the attitude scale of the SDIS contains only 12 of the 30 factual statements that originally appeared in the SDQ. The reliability of the three scores reported by the SDQ was obtained from the evaluation of a random sample of 499 college students from six Southern colleges and universities. The Spearman-Brown analysis was used to establish split-half reliability, and it yielded coefficients of .79 for the responsibility scale, .73 for the knowledge scale, and .91 for the consequences scale (Gonzalez, 1978).

Test-retest reliability was established by using a sample of 83 to 87 University of Florida students. The SDIS was administered on two different occasions separated by an interval of 4 to 5 weeks. The Pearson Correlation coefficients achieved by this process were: $r = .79$ for the quantity-frequency scale; $r = .94$ for the responsibility scale; $r = .97$ for the knowledge scale; and $r = .81$ for the consequences scale. All of the coefficients are satisfactorily high.

Validity. The face validity of the attitude scale was established by asking a panel of experts to evaluate the items. They unanimously agreed that the scale would adequately measure responsible attitudes related to the use of alcohol. Gonzalez (1978) established the construct validity of both the responsibility and negative behavior consequences scale by testing the following null hypothesis: "There is no significant inverse relationship between the responsibility scale and the negative behavior consequences scale." Using a sample of 499 southern college students to test this hypothesis, the analysis yielded a Pearson Product moment correlation of $r = -.52$ between the two scales; this represents a significant inverse relationship ($p < .001$). This led to rejection of the null hypotheses, thereby establishing the construct validity of these scales.

Parental Alcoholism Information Survey

The Parental Alcoholism Information Survey (PAIS) (see Appendix J) was developed by this writer to measure knowledge, attitudes, and behavior related to parental alcoholism and its effects on the family. As implied in its name, this evaluation instrument is only intended for use with children with one or more alcoholic parent. The basic format for this survey is analagous to that adopted by Gonzalez in his SDIS. The items ultimately selected for inclusion in the three scales of the PAIS were the product of an intensive and exhaustive review of the literature related to parental alcoholism and its effects on the family.

Demographic Section. The survey begins with 21 questions designed to elicit background information concerning both the respondent and the problem of parental alcoholism. Examples of these questions are: "Which of your parents is (was) an alcoholic?" "How long have you lived with your alcoholic parent since their drinking first became a problem?" "Does your alcoholic parent acknowledge his/her alcoholism?"

Knowledge Scale. The knowledge scale (Section II) of this instrument contains 25 factual statements designed to test the respondent's knowledge of alcoholism and its effects on the family. These statements were assembled by the author following a thorough review of the literature. Response choices include true, false, and don't know. Total score for this section may range from 0-25, with each correct (true) response receiving a value of 1. Examples of the true-false statements are: "Alcoholics typically deny that they have a drinking problem, thereby enabling the disease of alcoholism to progress," "In addition to being a population at risk for developing alcoholism, children of alcoholics have a greater than average chance of encountering social and/or psychological difficulties later in life."

Healthy Coping Attitudes Scale. Section III contains the Healthy Coping Attitudes Scale, and it was used to test Hypotheses 6 and 6A of this study. The writer's literature review resulted in the identification of a total of 20 widely acknowledged coping reactions

of offspring to parental alcoholism. Eleven of these common responses are generally recognized to represent healthy attitudes (i.e., predispositions to behave in a certain way) for children of alcoholics. These are: (1) "feel that the first responsibility of spouse and children is to themselves, because there is nothing they can do to force the alcoholic to stop drinking," (2) "emotionally detach yourself from your parent's drinking and the problems at home (while still loving them)," (3) "respect your alcoholic parent when they are sober," (4) "feel that alcoholics hate themselves for not being able to control or stop their drinking," (5) "respect your nonalcoholic parent," (6) "take the fruit of your experiences--the tough things you saw as well as the positive and constructive experiences--and build them into the kind of life you want for yourself," (7) "think seriously about how you have been affected by your parent's alcoholism," (8) "admit to yourself that you have developed both strengths and weaknesses as a result of whatever role(s) you had to adopt in order to survive the experience of living with an alcoholic parent," (9) "be willing, as the offspring of an alcoholic, to accept the role of one who might need help," (10) "decide that it represents an act of love and concern on your part to let your alcoholic parents experience the consequences of their drinking," (11) "believe that by helping yourself, you are thereby better able to help your alcoholic parent."

The author identified nine other attitudes in the literature as representative of unhealthy modes of responding to the parental

drinking problem: (1) "feel frustrated by the alcoholic's behavior and their inability to control it," (2) "resent your alcoholic parent's drinking," (3) "be hesitant about making new friends or letting people know what you are really like for fear that they won't like you when they find out about your alcoholic parent," (4) "hold your alcoholic parent responsible for having the disease of alcoholism," (5) "feel guilty because of anger or other negative feelings toward one or both of your parents," (6) "feel that your parent would not drink if he really loved you," (7) "feel that if you were a better son or daughter, then your parent would not drink," (8) "hold yourself capable of and responsible for curing the alcoholism," (9) "feel ashamed about having an alcoholic parent."

The aforementioned healthy and unhealthy attitudes were incorporated into a 20-item attitude scale. These attitudes (predispositions to act in a certain way) are listed, and the respondents are then asked to indicate how likely they are to behave in the indicated manner by marking one of a continuum of five responses for each item: very likely, likely, somewhat likely, unlikely, and very unlikely. The eleven "healthy coping attitudes" are scored in a positive direction so that a "very likely" response is assigned a value of 5, while a "very unlikely" answer is given a value of 1. The remaining nine "unhealthy coping attitude" items are weighted in an inverse manner for scoring purposes. The range of scores for this scale is 100-20, with the higher score indicating a healthier

attitude for coping with the parental alcoholism. This scale thus provides a Likert-type attitude measurement scale for assessing the degree of healthy coping attitudes toward a parent's alcoholism (Isaac & Michael, 1971).

Healthy Coping Behavior Scale. The Healthy Coping Behavior Scale, which was used to test Hypotheses 7 and 7A of this investigation, constitutes Section IV of the survey. The behaviors selected for inclusion in this final section were also the product of the author's literature review. A total of 20 specific behaviors were identified as widely recognized instances of healthy or unhealthy ways of coping with parental alcoholism and its effects on the family. This section is divided into two parts; the first 14 statements are intended to be answered by all students, whereas the final six are only appropriate for those students whose parent is currently an active drinker and not in the midst of the recovery process.

Ten of the first fourteen behaviors (applicable to students with both active and recovering alcoholics as parents) represent behaviors that are healthy ways of coping with the family's drinking problem. These are: "I have discussed my worries about my alcoholic parent with a knowledgeable person outside the family," (2) "I have sought professional counseling when I felt the drinking problem at home might be affecting my personal life," (3) "I have attended an 'open' Alcoholics Anonymous meeting," (4) "I have attended an Alateen

or Al-Anon meeting," (5) "I have encouraged a nonalcoholic family member to attend an Alateen or Al-Anon meeting," (6) "I have provided other family members with helpful reading materials about the disease of alcoholism and its effects on the family," (7) I have expressed faith in my alcoholic parent's ability to recovery by showing support and/or giving sincere compliments," (8) "I have alerted my siblings to their high-risk level and tried to help them make informed choices about how to deal with these risks," (9) "I have closely monitored the physical and psychological effects of alcohol on myself when I drink," (10) "I have shared my feelings and concerns about my parent's drinking problem with a close friend I can trust." The remaining four behaviors portray unhealthy methods of coping. They are: (1) "I have hidden my parent's drinking problem from others and pretended that it did not exist," (2) "I have had trouble concentrating on school work due to worrying about my parent's drinking problem," (3) "I have, in a fit of temper, said or done things to my alcoholic parent that I did not want to, but could not help myself," (4) "I have resorted to drinking to solve a problem or because the day did not go right."

The final six statements, which comprise the second half of this final section, describe five unhealthy ways of coping and one healthy one for the child of an actively drinking alcoholic. The five unhealthy behaviors are (1) "I have gotten involved in a confrontation with my parent while they were drinking," (2) "I have

nagged, preached, coaxed, or lectured my parent about their drinking," (3) "I have berated or humiliated my parent because of their drinking," (4) "I have thrown out or hidden my parent's supply of alcohol," (5) "I have gotten into a discussion with my parent about whether they are an alcoholic or not." The healthy behavior is: "I have let my alcoholic parent know that help is available and that I want to help them get it."

These healthy and unhealthy coping behaviors thus identified were used to create a 20-item healthy coping behavior scale. These behaviors are listed, and the respondent is asked to indicate how many times during the last two months they performed each behavior; there are five responses to choose from for each item: never, once, twice, 3 times, and 4 times or more. Responses for each healthy behavior item are assigned a value ranging from 0 for "never" to 4 for "4 times or more," while a reverse scoring procedure applies to the unhealthy behavior items. This results in a theoretical range of scores of either 0-56 (if parent is in the midst of recovery process and not actively drinking) or 0-80 (if parent is actively drinking). Like the healthy coping attitudes scale, this healthy coping behavior scale is a Likert-type instrument; it assesses the degree of healthy coping behaviors related to parental alcoholism and its effects on the family.

Establishing reliability and validity of the research scale. The face validity of this survey instrument was established by means

of a panel composed of the following alcohol experts at the University of Florida: the Coordinator of the Alcohol Abuse Prevention Program, the Dean of Student Services, a clinical psychologist at the Student Mental Health Services, and two alcohol counselors at the Counseling Center. Each panel member was asked to evaluate the items on the basis of their appropriateness for measuring knowledge, attitudes, and behavior toward parental alcoholism and its effects on the family. They were unanimous in agreeing that this scale would provide an adequate measure.

In order to establish the reliability coefficient for the three scales of the PAIS, a group of 15 University of Florida students who met the criteria (see Appendix A) for having an alcoholic parent were asked to complete the Parental Alcoholism Information Survey (PAIS) during the 1980 Fall quarter and then again two weeks later. This group was a mixture of volunteers from the introductory psychology class, who received two hours of experimental credit for their participation, and other students voluntarily participating without receiving any remuneration. Using Pearson's Product-moment correlation coefficient procedure, the test-retest reliability coefficients obtained were as follows: knowledge scale, $r = .66$; healthy coping attitudes scale, $r = .87$; healthy coping behaviors scale, $r = .94$.

Data Collection

Pretest scores were obtained by jointly administering the Student Drinking Information Scale (SDIS) and the Parental Alcoholism

Information Survey (PAIS) during the week prior to the first scheduled meetings of the experiential and cognitive (educational counseling) groups. These same measures were administered to the delayed treatment control subjects during the same week.

The pretest was administered by the author to all members of the experimental and control groups. All subjects were thanked for their cooperation and told that honest, accurate answers were essential to the experiment's success. They were also assured that the information collected would be used for research purposes only and would be kept completely confidential. The anonymity of students was safeguarded by asking each student to write the last four digits of his or her Social Security number on each measurement instrument in lieu of his or her name. This procedure was necessary for identification and future matching purposes.

The posttests were administered in a similar fashion following the last scheduled meeting of each group. These posttests were then compared with pretests by using the respondents' numbers. Any unmatched tests were deleted from the study.

Two months after completion of the experimental procedure, the post-posttest was mailed to addresses obtained from all study subjects and recorded on note cards. A cover letter thanking them for their participation, assuring confidentiality, and stressing the importance of a prompt reply was enclosed, along with a self-addressed envelope (see Appendix K). Also, subjects were reminded

of their previous agreement (via the informed consent form) to fill out self-report questionnaires. If no response was received from some of the students within two weeks after the initial meeting, then a second set of questionnaires with an accompanying follow-up cover letter (see Appendix L) was sent to them. These individuals were identified for mailing by means of a checklist of Social Security numbers. Students failing to reply within two weeks of this second mailing were eliminated from the study for the purposes of the post-posttest data analysis. The minimum acceptable response for follow-up analysis was set at 70%. Twenty-eight (84.8%) of the 33 subjects filled out and returned the post-posttest questionnaires.

Data Analysis

The first step of the data analysis involved the testing of homogeneity of regression (i.e., test of equality of slopes) to determine if there was any evidence of significant interaction between the pretest and the treatments. This preliminary test was performed because the assumption of equality of slopes is a critical one in an analysis of covariance. If there was no indication of significant interaction, then the data were subjected to an analysis of covariance using pretest scores as covariates; this statistical procedure controlled for the main effects caused by the initial group differences. Pretest, posttest, and post-posttest questionnaires were matched by their identifying numbers so that each matched set could be treated as one case with repeated measures. The effect of treatment on each

dependent variable was separately analyzed for posttest and for post-posttest comparisons. An alpha level of .05 was established an an acceptable level of significance. When significant F-ratios were discovered, the source of variation was determined by conducting a post hoc multiple comparison test.

Responses to the instruments used in this investigation were hand scored and then coded for computer analysis. Computer facilities were used at the Northeast Florida Regional Data Center at the University of Florida and the Computation Center at the University of Texas at Austin.

Rationale for Methodology

Many ideas from the experimental treatment programs discussed earlier in Chapter II contributed to the design of this study of structured group counseling for university students with one or more alcoholic parent. Helpful as these early efforts were, their value was, nonetheless, limited by the extent to which they reflect the relatively underdeveloped state of research in this area. Consequently, it was necessary to look for more clearly defined guidelines from a related field that possessed a certain amount of methodological sophistication. Alcohol education was a logical place to turn to, and its approach to the vital issues of measurement and evaluation was applicable and transferable to a secondary prevention program specifically designed for children of alcoholics.

CASPAR's primary prevention program of alcohol education for grades 3 to 12 was the key to their successful work with children

from alcoholic families. A subunit on family alcoholism was included among topics covered in these courses at various age levels, and discussion of alcoholism was deliberately postponed until the latter part of the unit. In sharp contrast to this format, the curriculum developed for the structured groups composed entirely of children of alcoholics began with alcoholism and devoted the final two sessions to the matter of responsible decision making about alcohol (Deutsch et al., 1978). Unquestionably, the responsible use of alcohol is an important goal in most alcohol education programs; this is equally true for a secondary prevention program designed for offspring of alcoholics in spite of the different sequence and content of the matter presented to this group. If anything, this goal warrants even more emphasis in prevention efforts aimed at this special population, because so many (as many as 50%) of today's alcoholics are children of alcoholics (Chafetz, 1979).

In designing a revolutionary program of educational counseling for university students with one or more alcoholic parent, what can be learned from an assessment of previous alcohol and drug education models that can contribute to the greater effectiveness of this study? Consider these relevant observations from a recent, extremely extensive review of drug and alcohol education modules by Goodstadt (1978).

The Knowledge-Attitude-Behavior Model

The most glaring weakness of most drug education programs has been a general failure to make explicit their underlying

educational assumptions. Where these premises have been clearly stated, there have been few attempts to test them through an assessment of program effectiveness (Goodstadt, 1978). The purpose of the earlier minireview (see Chapter II) of selected studies (of alcohol education programs for college students) from the literature in this area was to profit from earlier efforts and incorporate their best features into design employed in this investigation. Besides being of obvious value to the responsible drinking component of this secondary prevention program, these studies have other implications that have helped in the design of facets of the program proposed in this study.

One of the most popular models used in drug education is based on a series of relationships between a person's knowledge about drugs, his/her feelings toward drugs, and his/her behavior in relation to drugs. Some of the basic assumptions underlying this knowledge-attitude-behavior (k-a-b) model have been seriously challenged by some recent findings (Goodstadt, 1978).

To begin with, the research literature suggests that knowledge alone is likely to have little impact on behavior; even though a correlation may be found between knowledge and behavior, no cause-effect relationship exists. There is little evidence to support the idea of attitudes representing a distinct and stable entity that have significant behavioral impact. The relationship between attitudes and behavior is an extremely complicated one (Goodstadt, 1978).

It is known that measures of attitude-to-act have more validity than attitudes-to-object or situation; in fact, the predicting power of the attitude measure varies in direct proportion to the specificity of the attitude act. There is, however, very little evidence to support the expectation that behavioral change will follow changes in attitude. Another significant finding is that a person's behavioral tendency or stated intention to perform a behavior is the best predictor of future behavior. It seems that drug educators are usually concerned with well-entrenched behavior patterns that are supported by social forces and are apt to be consistent with existing sets of attitudes. Consequently, it is not much of a surprise that even when attitudinal changes occur, corresponding behavioral changes do not necessarily follow; or, if behavioral changes initially take place, they will often, with time, give way to better-established patterns of behavior (Goodstadt, 1978).

Somewhat startling is the evidence which shows that attitudes are affected by behavior. This implies that a more fruitful means of effecting change might be to approach it through direct and indirect behavior influence rather than attitude change attempts. It further suggests that health-related behavior may be influenced through the process of leading a person to participate in behaviors, especially those which might effect changes in that individual's behavioral intentions (Goodstadt, 1978).

Limitations of the Study

This investigation was admittedly limited to a self-selected population of university students with an alcoholic parent who volunteered to participate in a five-week structured counseling group (for students with a family drinking problem). The results of this study are perhaps most valuable in terms of the generalizability of their implications for a far wider audience comprised of adult offspring of alcoholics. Some limitations to this research project deserve mention before considering the findings.

The primary limitation comes from the lack of complete control over the following threat to external validity: the reactive (interaction) effects of the experimental procedures. It is conceivable that the students' awareness of taking part in an experimental research program may have influenced their manner of responding to the measurement instruments. Also, the method of self-report used to collect the data is open to criticism on the grounds of possessing questionable validity. The use of self-report measures introduces the possibility of socially desirable response sets that would bias the results. Realistically, however, self-report is the only way to gather this type of information. These objections are somewhat offset by evidence in the literature which suggests that a reasonable amount of confidence can be placed in self-reported responses concerning drug habits (Ball, 1967; Globetti & Brigance, 1971; Gossett, Lewis, & Phillips, 1971; Leutgart & Armstrong, 1973--all

cited in Schlegel, 1977). Various options for validating self-report were considered but rejected for reasons of impracticality. Ultimately, it seems necessary to assume that the questionnaire data were basically accurate and at worse subject to a constant bias for all treatment conditions and data-collection points (Schlegel, 1977).

There are a few factors that could conceivably have imposed limitations on the applicability of the follow-up results. The individual history threat to internal validity might have become a relevant influence between the time of treatment and the post-post-test. This threat became more serious in light of the fact that the two-month follow-up period occurred during the summer months, a time when many students were at home rather than school. Another potential threat to internal validity was that the pretesting procedures might have induced subjects to alter their responses on the post-test and post-posttest measures regardless of whether or not they received experimental treatment.

The preceding discussion of possible limitations to this study was presented in the spirit and interest of scientific integrity; such a forthright approach runs the dangerous risk of planting perhaps a few too many seeds of doubt concerning the key issue of validity. While it is conceivable that any of these limiting factors might have come into play and thereby influenced this investigation's findings, the numerous strengths of this study's research design definitely outweigh any potential and unavoidable shortcomings.

CHAPTER IV
RESULTS

This study was designed to investigate the effectiveness of two different approaches to structured group counseling developed specifically for university students with an alcoholic parent. Each experimental group (experiential and cognitive) was compared to the other as well as with a delayed treatment control group. The following indices of change were examined: (1) the students' knowledge, attitudes, and behavior related to drinking; and (2) the students' attitudes, knowledge, and behavior pertaining to the parental alcoholism. Among the questions addressed was whether or not such an intervention would elevate the degree of responsibility in attitudes toward alcohol use, increase knowledge concerning alcohol, lower the respondent's level of alcohol consumption, and decrease the incidence of negative outcomes experienced as a result of drinking. In addition, this study sought to determine whether or not the educational group counseling would effect greater knowledge of alcoholism and its effects on the family, an increase in healthy coping attitudes toward parental alcoholism, and a rise in healthy behaviors for coping with the parent's illness.

Past efforts to evaluate effectiveness in the area of alcohol abuse prevention have traditionally included scales designed to measure changes in knowledge and in attitudes; however, experts

in this field have deemed the variable which measures negative behavioral consequences as both the most critical and most elusive target of their endeavors. By application of a somewhat similar and parallel reasoning process in investigating the main effects of this study's approaches to secondary prevention, the incidence of healthy coping behaviors clearly emerges as the most stringent and critical variable for evaluating the success of this intervention.

A total of 33 students participated in the study -- 11 in the experiential group, 8 in the cognitive group, and 14 in the control group. Students responding to the offer of educational group counseling for individuals with a problem-drinking parent were randomly assigned to one of the three groups with practical (i.e., scheduling) considerations operating as the primary determinants in final placement decisions. A total of 28 (84.8% of the original sample of subjects) students took part in the two-month follow-up study. Of these, 10 were in the experiential group, 7 were in the cognitive group, and the remaining 11 comprised the control group.

Of the seven dependent variables examined (see p. 84 for their listing), four were directly related to the respondent's status as a drinker. Consequently, no scores were obtained from the abstainers on either the knowledge scale or the responsible drinking scale of the Student Drinking Information Scale (SDIS); this sub-group was assigned a score of zero on the remaining two drinking scales (Quantity-Frequency Index of alcohol consumption; negative

behavioral consequences of excessive drinking). Level of alcohol consumption was determined by computing an individual's Quantity-Frequency (Q-F) Index of drinking behavior. Responsible attitudes toward alcohol use corresponded to the subject's mean score on the responsibility scale of the SDIS, with a high score indicating a responsible attitude. Knowledge about alcohol was measured by a student's total number of correct responses on the knowledge scale of the SDIS. All scores represent self-reported drinking behavior only.

The remaining three dependent variables under investigation related directly to the respondent's alcoholic parentage. Thus, scores were available for all of the participants. Knowledge of alcoholism and its effects on the family corresponded to the total number of correct responses on the knowledge scale of the Parental Alcoholism Information Survey (PAIS). Healthy coping attitudes toward parental alcoholism were measured by the subject's mean score on the attitude scale of the PAIS; similarly, healthy coping behavior was determined by calculating the student's mean score on the behavior scale of the PAIS. With both of these healthy coping scales, attitudes and behavior, there was a direct correlation between healthy coping and a high score. The PAIS resembles the SDIS in that it is also a self-report instrument.

A test of homogeneity of regression (Wilson & Carry, 1969) and an analysis of covariance (Winer, 1962) were the two primary statistical procedures used to analyze the data in this study. The

process of statistical analysis involved several stages which resulted in either retention or rejection of the research hypotheses. The purpose of the initial step of the analysis (the test of homogeneity of regression) was to determine if there was evidence of significant interaction between the pretest and the treatments. The finding of significant interaction invalidated a basic assumption underlying the analysis of covariance; the assumption is that the relationship between the response and covariate is linear and that the slope of the regression line is the same for all treatments. When this preliminary test of equality of slopes (i.e., the test of homogeneity of regression) failed to confirm this fundamental assumption, the analysis of covariance lost its statistical validity as a test of the hypothesis and thus was not performed. This necessitated the decision to retain the null hypothesis, because the absence of a valid statistical tool made it impossible to test the hypothesis and thereby justify its rejection. The null hypothesis was retained by default, because there was no means of proving otherwise according to the criteria already established. However, a graph of the posttest-pretest regression lines enabled the making of an interpretation (by means of suggestive evidence) concerning the nature of the interaction between the pretest score (e.g., high or low) and the treatment.

When the test of homogeneity of regression indicated the absence of interaction between the pretest and the treatments, an analysis of covariance was carried out to determine if the three

groups were significantly different on pretest and posttest measures of the above dependent variables. An analysis of covariance made it possible to reject a particular null research hypothesis independent of the subject's pretest score.

An alpha level of .05 was selected as the basis for rejecting the null hypothesis, thereby establishing a 95% confidence interval for the results obtained. Bonferroni-Dunn's procedure (Myers, 1979) was used in making post hoc comparisons on adjusted means to determine the source of significant variation.

The hypotheses were initially tested immediately following completion of the group counseling and then again two months later to determine if observed effects were immediate, delayed, or remaining over two months. The remainder of this chapter furnishes a detailed description of the results of the testing of each hypothesis (see pp. 139-142 for a concise, summarized listing of findings). Note that numbers appearing in the tables have been rounded off to the second decimal place.

Results of Tests of Hypotheses

Hypothesis 1A

There will be no differences between students in the experimental and control groups on the Quantity-Frequency Index of alcohol consumption following their participation in educational counseling.

Hypothesis 1B

There will be no differences between students in the experiential and cognitive groups on the Quantity-Frequency Index of alcohol consumption following their participation in educational counseling.

Statistical analysis of the data collected immediately after treatment produced evidence of significant ($p < .01$) interaction between the pretest and the treatments. More specifically, the test of homogeneity of regression revealed a significant difference between the slope for the control group and the slopes for the experiential ($p < .01$) and cognitive ($p < .001$) groups (see Table 2). Consequently, an analysis of covariance was not performed.

The graph of the posttest-pretest regression lines (see Figure 1) suggests that for high Q-F pretest indices, both the experiential and cognitive treatment groups had an effect relative to the control.

Close examination of the graph of the posttest-pretest scores (not shown here) indicated that the treatment effect observed in the control group was probably due to one subject. This student showed a dramatic rise in the Q-F Index of alcohol consumption (from a pretest score of 40 to 80 on the posttest). This example of a rapid increase in the Q-F Index of a member of the delayed treatment control group further suggests that individuals deprived of intervention in the form of educational counseling are perhaps especially

Table 2

Homogeneity of Regression of Posttest Scores Adjusted for Pretest Scores of Quantity-Frequency Index of Alcohol Consumption Among Experiential, Cognitive, and Control Groups

Source	SS	DF	MS	F
Pretest	14531.27	1	14531.27	361.41***
Main Effects	42.35	2	21.18	.53
Pretest x Main Effects	589.00	2	294.50	7.25**
Error	1085.59	27	40.21	

N	Group	Estimated Slope	Experiential 1.02	Cognitive 1.00	Control 1.55
11	Experiential	1.02	---	.02	-.53**
8	Cognitive	1.00		---	-.58***
14	Control	1.55			---

***$p < .001$
**$p < .01$
*$p < .05$

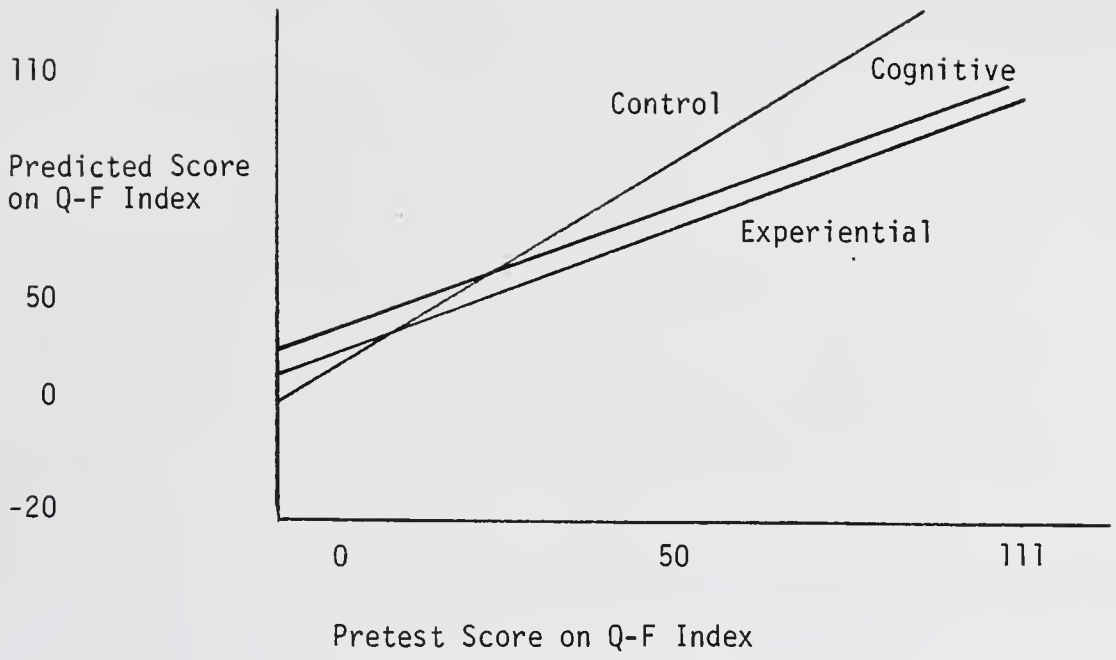

Figure 1. Graph of posttest-pretest regression lines for quantity-frequency index of alcohol consumption among experiential, cognitive, and control groups.

vulnerable to markedly increased alcohol intake. It is presumably more than coincidental that this case involved a person in the control group. The implicit assumption is that this dramatic elevation might have been abated if not totally averted had the subject been exposed to one of the experimental treatment programs.

While these findings are insufficient to warrant the rejection of Hypothesis 1A, they provide evidence which suggests that for high Q-F pretest indices, both experimental treatment groups do yield lower posttest scores on the Q-F Index than the control group. Hypothesis 1B was also retained, since posttest analysis of Figure 2 disclosed no evidence of any significant differences between the experiential and cognitive groups on the Q-F Index.

Analysis of the data gathered two months after the completion of treatment satisfied the key assumption of equal slopes, and an analysis of covariance was conducted.

Table 1A reveals no significant differences between the three treatment groups on the Q-F Index variable. Consequently, both null hypotheses 1A and 1B were retained for the effects of treatment after a two-month follow-up period.

Hypothesis 2A

There will be no differences between students in the experimental and control groups on knowledge concerning alcohol after participation in educational counseling by members of the experimental groups.

Table 3

Analysis of Covariance of Post-Posttest Scores Adjusted for Pretest Scores of Quantity-Frequency Index of Alcohol Consumption Among Experiential, Cognitive, and Control Groups

Source	SS	DF	MS	F
Pretest	15425.11	1	15425.11	97.96***
Main Effects	102.59	2	51.30	0.33
Error	3779.14	24	157.46	

N	Group	Adjusted Mean
10	Experiential	16.37
7	Cognitive	14.70
11	Control	19.40

***$p < .001$

Hypothesis 2B

There will be no differences between students in the experiential and cognitive groups on knowledge regarding alcohol after participation in educational counseling.

A test of homogeneity of regression (see Table 3) reveals that the slopes of the posttest regression lines are not equal due to significant interaction ($p < .05$) between the pretest and the main effects of treatment. Table 3 indicates a significant difference ($p < .05$) in slopes of the regression lines between the slope of the cognitive group and that of the control group; there is a marginally significant difference ($p < .10$) in slopes when the experiential and cognitive groups are compared (see Figure 2).

A look at the graph of the posttest-pretest scores (not shown here) suggests a possible explanation for the observed differences in slopes of the regression lines (Table 3). In contrast to their counterparts in the experiential and control groups, subjects in the cognitive group with low to moderate pretest scores achieved dramatically elevated scores on the posttest measure of knowledge about alcohol. This somewhat unexpected finding is perhaps directly attributable to the cognitive emphasis placed on the structured counseling received by this group. It makes sense that a cognitively based approach might exert a more drastic impact in terms of increased gains in knowledge for subjects with low to medium scores on this variable than would an experientially based treatment approach.

Table 3

Homogeneity of Regression of Posttest Scores Adjusted for Pretest Scores of Knowledge About Alcohol Among Experiential, Cognitive, and Control Groups

Source	SS	DF	MS	F
Pretest	35.58	1	35.58	19.01***
Main Effects	29.92	2	14.96	7.99**
Pretest X Main Effects	14.50	2	7.25	3.87*
Error	41.18	22	1.87	

N	Group	Estimated Slope	Experiential .65	Cognitive .02	Control .90
8	Experiential	.65	--	.63#	-.25
7	Cognitive	.02		--	-.88*
13	Control	.90			--

***p < .001
**p < .01
*p < .05
#p < .10

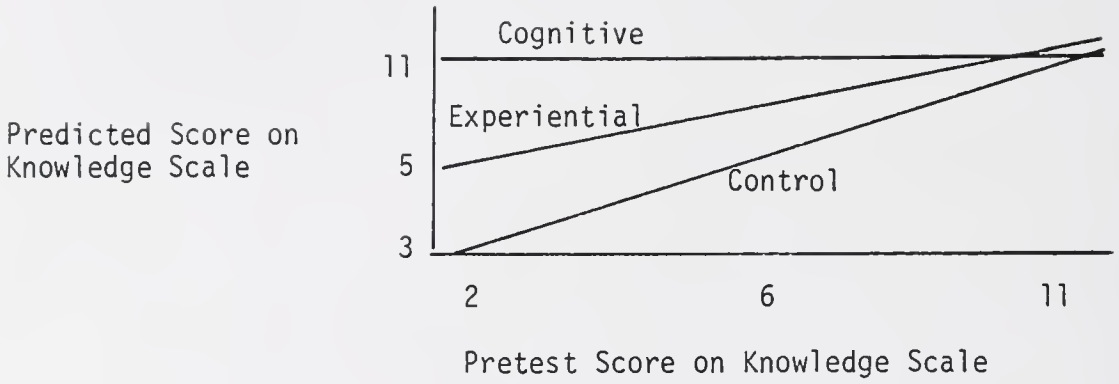

Figure 2. Graph of posttest-pretest regression lines for knowledge about alcohol among experiential, cognitive, and control groups.

Although these findings do not invalidate the decision to retain Hypothesis 2A for the immediate effects of treatment, they do suggest that for low to moderate pretest scores on the knowledge scale, the cognitive group demonstrated marked increases in post-test results when compared with the control group. Hypothesis 2B was likewise retained for the effects immediately following counseling, but there was evidence suggestive of conspicuously higher scores recorded on the posttest measure of knowledge about alcohol by students in the cognitive group with a low to medium pretest score compared to their counterparts in the experiential group.

The test of homogeneity of regression of the post-posttest results for the knowledge about alcohol subscale revealed no evidence of significant interaction between the pretest and the main effects of treatment. An examination of Table 14 reveals a significant (0.1 level) F-ratio for the main effects of treatment two months after treatment. This same table also shows that the adjusted mean score for the cognitive group was significantly higher ($p < .05$) on the knowledge subscale than it was for the experiential group. Therefore, both null Hypotheses 2A and 2B were rejected for the effects of treatment two months following the completion of counseling.

Table 4

Analysis of Covariance of Post-Posttest Scores Adjusted for Pretest Scores of Knowledge About Alcohol Among Experiential, Cognitive, and Control Groups with Bonferroni-Dunn's Comparisons Among Means

Source	SS	DF	MS	F
Pretest	34.01	1	34.01	19.63***
Main Effects	29.79	2	14.90	8.60**
Error	32.92	19	1.73	

N	Group	Adjusted Mean	Experiential 8.46	Cognitive 10.60	Control 7.81
7	Experiential	8.46	--	-2.14*	.65
6	Cognitive	10.60		--	2.79*
10	Control	7.81			--

***$p < .001$
**$p < .01$
*$p < .05$

Hypothesis 3A

There will be no difference between students in the experimental and control groups on responsible attitudes toward drinking following participation in educational counseling by subjects in the experimental groups.

Hypothesis 3B

There will be no differences between students in the experiential and cognitive groups on responsible attitudes toward drinking after participation in educational counseling.

The key assumption of equal slopes was validated for the data on the immediate effects of treatment, and an analysis of covariance was performed. Table 5 indicates no significant difference in scores between the three treatment groups on the variable associated with responsible attitudes toward alcohol. Therefore, both the null Hypotheses, 3A and 3B, were retained.

As Table 6 makes evident, an analysis of the follow-up data also uncovered no significant differences in scores between the three treatment groups on the variable related to responsible attitudes toward alcohol two months subsequent to treatment. This led to retention of Hypothesis 3A and 3B for the effects of treatment following the post-treatment period of two months.

Hypothesis 4A

There will be no differences between students in the experimental and control groups on negative behavioral consequences

Table 5

Analysis of Covariance of Posttest Scores Adjusted for Pretest Scores of Attitudes Concerning Alcohol Among Experiential, Cognitive, and Control Groups

Source	SS	DF	MS	F
Pretest	2187.20	1	2187.20	61.85***
Main Effect	46.18	2	23.09	0.65
Error	848.77	24	35.36	

N	Group	Adjusted Mean
8	Experiential	84.05
7	Cognitive	80.67
13	Control	81.76

***$p < .001$

Table 6

Analysis of Covariance of Post-Posttest Scores Adjusted for Pretest Scores of Attitudes Concerning Alcohol Among Experiential, Cognitive, and Control Groups

Source	SS	DF	MS	F
Pretest	2103.08	1	2103.08	1.84
Main Effects	172.60	2	68.30	44.76**
Error	892.70	19	46.98	

N	Group	Adjusted Mean
7	Experiential	84.69
6	Cognitive	85.20
10	Control	79.19

**$p < .01$

of alcohol abuse after participation in educational counseling by members of the experimental groups.

Hypothesis 4B

There will be no differences between students in the experiential and cognitive groups on negative behavioral consequences of alcohol abuse following participation in educational counseling.

A test of homogeneity of regression for the negative behavioral consequences scale produced no evidence of significant interaction between the pretest and the main effects of treatment on data collected immediately after treatment. An analysis of covariance was then performed (see Table 7), and it revealed no significant differences in scores between the three treatment groups on this dependent variable. This finding led to retention of both Hypothesis 4A and 4B.

Statistical analysis of data collected two months following treatment revealed evidence of significant ($p < .001$) interaction between the pretest and the treatments. More specifically, the test of homogeneity of regression for the negative consequences scale indicated a significant difference between the slope for the control group and the slopes for the experiential ($p < .001$) and cognitive ($p < .001$) groups (see Table 8). As a result, an analysis of covariance was not performed.

The graph of the post-posttest regression lines (see Figure 3) suggests that for high pretest indices of negative behavioral

Table 7

Analysis of Covariance of Posttest Scores Adjusted for Pretest Scores of Incidences of Negative Behavioral Consequences Among Experiential, Cognitive and Control Groups

Source	SS	DF	MS	F
Pretest	558.42	1	558.42	89.39***
Main Effects	3.78	2	1.89	0.30
Error	181.16	29	6.25	

N	Group	Adjusted Mean
11	Experiential	2.96
8	Cognitive	3.50
14	Control	3.74

***$p < .001$

Table 8

Homogeneity of Regression of Post-Posttest Scores Adjusted for Pretest Scores of Negative Behavioral Consequences of Alcohol Abuse Among Experiential, Cognitive, and Control Groups

Source	SS	DF	MS	F
Pretest	583.53	1	583.53	64.20***
Main Effects	14.52	2	7.26	0.80
Pretest X Main Effects	178.02	2	89.01	9.79***
Error	199.96	22	9.09	

N	Group	Adjusted Mean
10	Experiential	.64
7	Cognitive	.63
11	Control	1.67

***$p < .001$

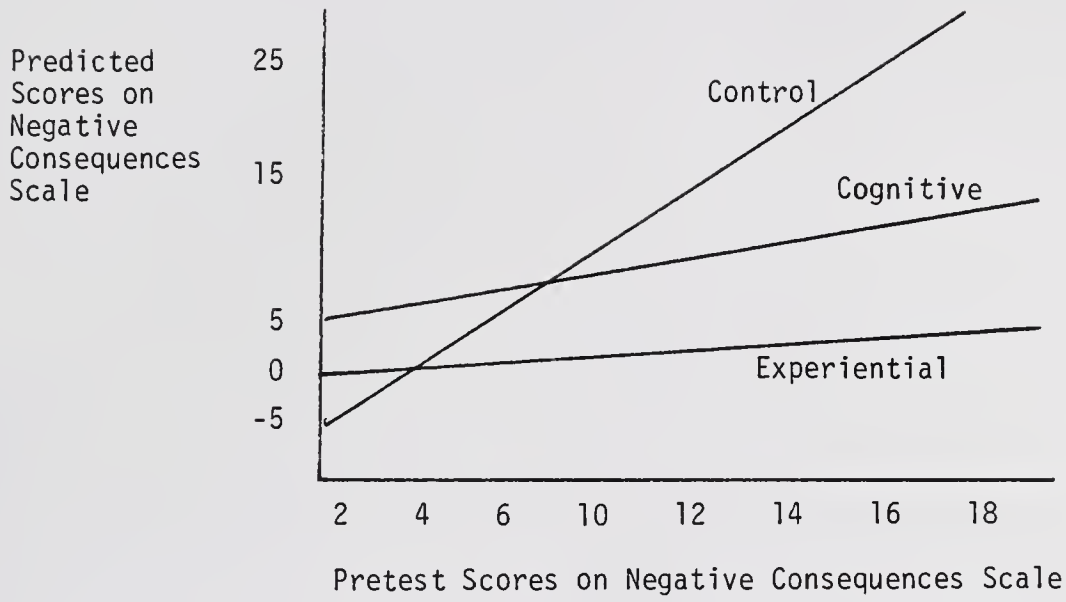

Figure 3. Graph of post-posttest regression lines for incidences of negative behavioral consequences among experiential, cognitive, and control groups.

consequences, both the experiential and cognitive treatment groups have an effect relative to the control.

Close examination of the graph of the post-posttest pretest scores (not shown here) reveals that the treatment effect witnessed in the control group was probably due to one subject. This individual reported a dramatic increase in negative behavioral consequences of drinking (from a pretest score on 15 to 28 on the post-posttest). This example of a rapid rise on the negative behavioral consequences scale further suggests the possibility that individuals deprived of intervention in the form of educational counseling are perhaps especially vulnerable to experiencing greatly increased negative behavioral consequences of drinking alcohol. The assumption is that this student's membership in the control group was more than a matter of mere coincidence; a conceivable and plausible explanation is that the marked increase in the student's score on this subscale might have been averted or substantially curtailed had the subject been a member of one of the experimental treatment groups.

Null Hypothesis 4A was retained, but these findings suggest that for high pretest indices of negative behavioral consequences, both experimental treatment groups yield lower scores on this scale than the control group. Hypothesis 4B was also retained for the effects of treatment two months after treatment, because post-posttest analysis of Figure 3 revealed no evidence of any significant differences between the experiential and cognitive groups on this subscale.

Hypothesis 5A

There will be no differences between students in the experimental and control groups on knowledge about alcoholism and its effects on the family after participation in educational counseling by members of the experimental groups.

Hypothesis 5B

There will be no differences between students in the experiential and cognitive groups on knowledge about alcoholism and its effects on the family following participation in educational counseling.

Finding that the key assumption of equality of slopes was satisfied, an analysis of covariance was performed on the data collected immediately following treatment. The results of this statistical procedure (shown in Table 9) indicate that both the experiential and cognitive groups scored significantly ($p < .05$) higher than the control group on the knowledge scale immediately after counseling. Consequently, null Hypothesis 5A was uniformly rejected. Hypothesis 5B was retained, since Table 9 reveals no significant differences in scores on this knowledge subscale between the experiential and cognitive groups.

Statistical analysis of the data on the post-posttest scores of knowledge about alcoholism and its effects on the family led to the performance of an analysis of covariance. These results are presented in Table 10; they show that although the experiential and

Table 9

Analysis of Covariance of Posttest Scores Adjusted for Pretest Scores of Knowledge About Alcoholism and its Effects on the Family Among Experiential, Cognitive, and Control Groups with Bonferroni-Dunn's Comparisons Among Means

Source	SS	DF	MS	F
Pretest	84.36	1	84.36	20.51***
Main Effects	101.90	2	50.95	12.39***
Error	119.26	29	4.11	

N	Group	Adjusted Mean	Experiential 17.91	Cognitive 19.18	Control 14.83
11	Experiential	17.91	--	-1.27	3.08*
8	Cognitive	19.18		--	4.35*
14	Control	14.83			--

***$p < .001$
*$p < .05$

Table 10

Analysis of Covariance of Post-Posttest Scores Adjusted for Pretest Scores of Knowledge About Alcoholism and its Effects on the Family Among Experiential, Cognitive, and Control Groups with Bonferroni-Dunn's Comparison Among Means

Source	SS	DF	MS	F
Pretest	92.42	1	92.42	9.96**
Main Effects	57.99	2	28.99	3.13#
Error	222.63	24	9.28	

N	Group	Adjusted Mean	Experiential 18.99	Cognitive 18.66	Control 15.80
10	Experiential	18.99	--	.36	3.19#
7	Cognitive	18.61		--	2.81
11	Control	15.80			--

**$p < .01$
#$p < .10$

cognitive groups scored higher than the control group on this subscale two months after treatment (p = .06), the difference in not quite large enough to fulfill the criteria established earlier for an acceptable level of statistical significance. There were no significant differences in scores on this subscale between the experiential and cognitive groups. Therefore, both null Hypotheses, 5A and 5B were retained.

Hypothesis 6A

There will be no differences between students in the experimental and control groups on healthy coping attitudes for children of alcoholics after participation in educational counseling.

Hypothesis 6B

There will be no differences between students in the experiential and cognitive groups on healthy coping attitudes for children of alcoholics after participation in educational counseling.

A test of homogeneity of regression revealed no evidence of significant interaction between the pretest and the main effects of treatment for this particular dependent variable immediately following treatment. With the vital assumption of equal slopes thereby validated, an analysis of covariance was performed. Table 11 shows that there was a significant (.01 level) F-ratio for the main effects of treatment immediately following termination of the groups. This table also indicates that the cognitive group scored significantly higher (p < .05) than the delayed treatment control group on

Table 11

Analysis of Covariance of Posttest Scores Adjusted for Pretest Scores of Healthy Coping Attitudes Among Experiential, Cognitive, and Control Groups with Bonferroni-Dunn's Comparison Among Means

Source	SS	DF	MS	F
Pretest	266.75	1	266.75	5.94*
Main Effects	488.16	2	244.08	5.43**
Error	1303.30	29	44.94	

N	Group	Adjusted Mean	Experiential 78.87	Cognitive 81.77	Control 72.59
11	Experiential	78.87	--	-2.90	6.28#
8	Cognitive	81.77			9.18*
14	Control	72.59			--

**$p < .01$
*$p < .05$

marginally significant trend

the healthy coping attitude subscale immediately after counseling. Furthermore, the data indicate a marginally significant trend in the direction of higher scores on the healthy coping attitudes subscale by the experiential group compared to the control group immediately following treatment. This means that Hypothesis 6A was uniformly rejected, whereas the finding of insignificant differences between the two experimental groups on this subscale necessitated retention of Hypothesis 6B.

When the results of a test of homogeneity of regression discounted the possibility of significant interaction between the pretest and the main effects of treatment for this dependent variable, an analysis of covariance was carried out on this follow-up data. Table 12 shows that there was a significant ($p < .01$) F-ratio for the main effects of treatment two months subsequent to termination of the counseling. Hypothesis 6A was uniformly rejected, but Hypothesis 6B was retained as a result of the evidence indicating no significant difference between the two experimental treatment groups. More specifically, the cognitive group scored significantly higher ($p < .05$) than the delayed treatment control group.

Hypothesis 7B

There will be no differences between students in the experimental and control groups on healthy coping behaviors after participation in educational group counseling by members of the experimental groups.

Table 12

Analysis of Covariance of Post-Posttest Scores Adjusted for Pretest Scores of Healthy Coping Attitudes Among Experiential, Cognitive, and Control Groups with Bonferroni-Dunn's Comparison Among Means

Source	SS	DF	MS	F
Pretest	673.26	1	673.26	15.33***
Main Effects	547.32	2	273.66	6.23**
Error	1054.19	24	43.92	

N	Group	Adjusted Mean	Experiential 75.56	Cognitive 83.79	Control 72.17
10	Experiential	76.56	--	-7.23	4.39
7	Cognitive	83.79		--	11.62*
11	Control	72.17			--

***$p < .001$
**$p < .01$
*$p < .05$

Hypothesis 7B

There will be no differences between students in the experiential and control groups on healthy coping behaviors following participation in educational counseling.

An analysis of covariance was performed on the data collected immediately after treatment, and Table 13 indicates that there was a significant difference ($p < .01$) between the three groups. The test of comparisons among means revealed that the experiential group scored significantly ($p < .05$) higher than the control group immediately after counseling. There is also evidence of a marginally significant trend in the direction of higher scores on the healthy coping behavior scale by the experiential group in comparison to the cognitive group. Therefore, Hypothesis 7A was rejected, whereas Hypothesis 7B was retained.

Statistical analysis of the data collected two months after treatment included an analysis of covariance. Examination of Table 13 indicates that there was no significant difference between the three groups. There is evidence, however, of a marginally significant trend in the direction of higher scores on the healthy coping behavior scale by the experiential group in comparison to both the cognitive and control groups. Nonetheless, both Hypothesis 7A and 7B were retained according to the criterion established earlier for statistical significance.

Table 13

Analysis of Covariance of Posttest Scores Adjusted for Pretest Scores of Healthy Coping Behaviors Among Experiential, Cognitive, and Control Groups with Bonferroni-Dunn's Comparisons Among Means

Source	SS	DF	MS	F
Pretest	1382.83	1	1382.83	19.21**
Main Effects	892.76	2	446.38	6.20**
Error	2015.88	28	72.00	

N	Group	Adjusted Mean	Experiential 43.39	Cognitive 35.03	Control 31.19
11	Experiential	43.39	--	8.36#	12.20*
8	Cognitive	35.03		--	3.81
14	Control	31.19			--

**$p < .01$
*$p < .05$
marginally significant trend

Table 14

Analysis of Covariance of Post-Posttest Scores Adjusted for Pretest Scores of Healthy Coping Behaviors Among Experiential, Cognitive, and Control Group with Bonferroni-Dunn's Comparisons Among Means

Source	SS	DF	MS	F
Pretest	1147.69	1	1147.69	12.41**
Main Effects	304.39	2	152.70	1.65
Error	2126.74	23	92.46	

N	Group	Adjusted Mean	Experiential 39.43	Cognitive 33.02	Control 32.15
10	Experiential	39.43	--	6.41#	7.28#
7	Cognitive	33.02		--	0.87
10	Control	32.15			--

**$p < .01$

\# marginally significant trend

The following list provides a summary of results obtained from the study:

1. Immediately following treatment there was significant interaction ($p < .01$) between the pretest and the treatments for the variable denoting the Quantity-Frequency Index of alcohol consumption. Evidence suggests that for high Q-F pretest indices, both the experiential and cognitive treatment groups yielded lower posttest scores than did the control group.

2. No significant differences were found on the Quantity-Frequency Index of alcohol consumption between the experiential and cognitive groups immediately following treatment.

3. No significant differences on the Quantity-Frequency Index of alcohol consumption were found among the three groups two months following treatment.

4. Immediately following treatment there was a significant interaction ($p < .05$) between the pretest and the treatments for the variable; knowledge about alcohol. Evidence suggests that for subjects with low to moderate pretest scores, higher levels of knowledge about alcohol were found in the cognitive group than in either the control group or the experiential group immediately after treatment.

5. Significantly higher ($p < .05$) levels of knowledge about alcohol were found in the cognitive group than in the experiential group and the control group two months following treatment.

6. No significant differences in responsible attitudes concerning alcohol were found among the three groups immediately following treatment and two months later.

7. No significant differences in negative consequences of drinking were found among the three groups immediately after treatment.

8. There was evidence of significant interaction between the pretest and the treatments for the variable denoting negative consequences of drinking two months subsequent to treatment. The evidence suggested that for high pretest indices of negative behavioral consequences, both experimental groups yielded lower scores on this scale than the control group.

9. No significant differences in negative behavioral consequences of drinking were found between the experiential and cognitive groups two months after treatment.

10. Significantly higher levels of knowledge about alcoholism and its effects on the family were found in the experiential group ($p < .05$) and in the cognitive group ($p < .05$) than in the control group immediately following treatment.

11. No significant differences in levels of knowledge about alcoholism and its effects on the family were found between the experiential and cognitive groups immediately following counseling.

12. No significant differences in knowledge about alcoholism and its effects on the family were found among the three groups two months later. However, there was evidence of a marginally

significant trend in the direction of increased knowledge about alcoholism and its effects on the family found in both experimental groups when compared to the control group.

13. Significantly higher levels of healthy coping attitudes for children of alcoholics were found in the cognitive group ($p < .05$) than in the control group immediately following treatment.

14. Evidence of a marginally significant trend in the direction of higher levels of healthy coping attitudes for children of alcoholics was found in the experiential group compared to the control group immediately after treatment.

15. Significantly higher levels of healthy coping attitudes for children of alcoholics were found in the cognitive group ($p < .05$) than in the control group two months following counseling.

16. No significant differences in levels of healthy coping attitudes for children of alcoholics were found between the cognitive and experiential groups either immediately following or two months after treatment.

17. Significantly higher levels of healthy coping behaviors were found in the experiential group ($p < .05$) compared to the control group immediately after treatment.

18. There was evidence of a marginally significant trend in the direction of higher scores on the healthy coping behavior scale by the experiential group compared to the cognitive group immediately following treatment.

19. No significant differences in healthy coping behaviors were found among the three groups two months after treatment. However, there was evidence of a marginally significant trend ($p < .10$) in the direction of higher scores on the healthy coping behavior scale by the experiential group in comparison with both the cognitive and control groups two months subsequent to treatment.

CHAPTER V
SUMMARY, DISCUSSION, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

Summary

This study examined the relative effectiveness of two approaches to secondary prevention that were developed specifically for university students with an alcoholic parent. The study was designed to evaluate the impact of two types of educationally structured group counseling on the following variables: (1) the students' attitudes, knowledge, and behavior related to alcohol consumption, and (2) the students' knowledge, attitudes, and behavior associated with the parental alcoholism. The two approaches to educational counseling consisted of experiential and cognitive small groups. Each experimental treatment group consisted of five weekly, two-hour sessions, and both were offered under the auspices of the Counseling Center at the University of Florida. The groups employed different formats to address the same issues.

The experiential approach was an innovative one developed by the author to provide students with various opportunities to actually experience and engage in desirable behaviors relevant to the task of coping effectively with parental alcoholism. A noteworthy issue that received special attention was a sensitive one which concerned the personal decision regarding the role of alcohol use in

their own lives. Included among activities made available were the options to visit either a local detoxification center, a Veterans Administration hospital's treatment program for alcoholics, or an "open" Alcoholics Anonymous meeting. Additionally, all group members attended an Al-Anon meeting as well as planned and participated in a "responsible drinking" cocktail party. Role playing was another prominent feature of the experiential approach, and the topics covered included healthy coping attitudes and behaviors (for dealing with an alcoholic parent), responsible drinking behavior, and a simulated Alateen meeting (prompted by the absence of an Alateen group in Gainesville that could be attended).

The cognitive approach was comprised of activities performed within the confines of the group's weekly meeting place. Films, guest speakers, group discussions, and values clarification were the distinguishing features of this treatment mode. The activities in both groups were planned to cover the same basic concepts, and all group members received identical literature addressing the weekly topics.

Students responding to the offer of educational group counseling for individuals with a problem drinking parent were randomly assigned to either the cognitive or experiential group, with scheduling factors constituting the primary determinants in final placement decisions. Students with schedule conflicts that precluded membership in one of the experimental groups were assigned to the delayed

treatment control group. The cognitive group consisted of eight students, while eleven students comprised the experiential group. Scheduling difficulties necessitated dividing students designated for experiential group exposure into two somewhat smaller groups consisting of five and six members. The writer led all of the experimental groups, and expert supervision was provided by Dr. Milan Kolarik, a counseling psychologist and former Director of the Counseling Center at the University of Florida.

The experiential and cognitive experimental groups were then compared with a delayed treatment control group on the basis of posttests administered immediately following termination of the educational counseling groups and then two months later. Two sets of dependent variables were investigated. The impact of the experimental group on the students' knowledge, attitudes, and behavior concerning the personal use of alcohol was assessed in terms of the following dependent variables: (1) Quantity-Frequency Index of alcohol consumption, (2) knowledge about alcohol, (3) responsible-irresponsible attitudes about drinking, and (4) negative behavioral consequences of drinking. In the other major area examined in this study, the variables chosen for evaluation related specifically to the respondent group's shared status as children of alcoholics. These three dependent variables were: (1) knowledge about alcoholism and its effects on the family, (2) healthy coping attitudes for children of alcoholics, and (3) healthy coping behaviors for students

of alcoholic parentage. The effects of treatment on these two groupings of variables were measured by the subjects' responses on the corresponding scales of the Student Drinking Information Scale (SDIS) and the Parental Alcoholism Information Survey (PAIS).

Each of the above variables were analyzed for differences among all three groups. The primary statistical procedure used for this purpose was analysis of covariance using pretest scores as covariates. In addition, a preliminary test of homogeneity of regression was conducted to test the validity of a key assumption underlying the analysis of covariance (i.e., the equality of slopes). When differences between groups were revealed, Bonferroni-Dunn's post hoc multiple comparison test was carried out to determine the source of the observed differences. The analyses were performed on data collected immediately after completion of the structured counseling groups and on follow-up data gathered two months later.

Discussion

Preliminary analysis of the significant findings clearly indicates that the Parental Alcoholism Information Scale (PAIS) outperformed the Student Drinking Information Scale (SDIS) and represented a better investment in terms of yielding more results that were significant. All three of the dependent variables contained in the PAIS reflected significant effects of treatment, whereas only one of the four indices of change embedded in the SDIS produced significant results. The superior sensitivity demonstrated by the

PAIS as an evaluation instrument in this investigation warrants some comment and an attempt at understanding the reasons for it. The PAIS may simply be a more sensitive measurement tool than the SDIS; however, a more palatable explanation may stem from the fact that the rationale, goals, and content focus of the educational counseling groups correlated far more strongly with the dependent variables monitored by the PAIS. The special needs of university students of alcoholic parentage were the most salient considerations involved in planning topics for the groups. In light of the subjects' high risk status for potentially becoming alcoholic, the matter of responsible decision making about alcohol was addressed specifically; however, it was just one of several topic areas covered in the sessions.

The lone significant finding to emerge from the SDIS data appeared on the subscale pertaining to knowledge about alcohol. While the evidence collected immediately after counseling suggested that the cognitive group demonstrated increases in knowledge about alcohol in comparison to both the experiential and control groups, this result did not reach a level of significance ($p < .05$) until two months after treatment. Since the rise in knowledge among the cognitive group members had evidently begun during the course of the structured counseling sessions, the question remains as to what factor(s) might have been operative following treatment and prior to the two-month follow-up posttesting. One possible explanation is that students in the cognitive group might not have had sufficient

opportunity to read the literature they received until spring quarter ended and summer break provided the necessary free time. Though plausible, that theory leaves unanswered the question of why members of the cognitive group would be more likely than the experiential group to expand their knowledge by reading the literature during the summer. Perhaps the two months simply represent the time required for the recently acquired knowledge to be completely learned and further reinforced.

The next major finding of significance appeared in the cognitive and experiential groups immediately after counseling. Both groups evidenced significant increases in knowledge about alcohol and its effects on the family ($p < .05$) when compared with the delayed treatment control group. Despite the fact that results showed that this change was not lasting over the next two months, there was still evidence suggestive of these changes in the post-posttest results. Maintaining the rises in knowledge that were so successfully effected proved to be an obstacle for both experimental treatment groups. The strong denial systems known to exist in members of an alcoholic's immediate family may account for the nonlasting nature of knowledge acquired by group members concerning alcoholism and its effects on the family; away from the influence of structured group counseling, it seems logical that former denial patterns would reassert themselves.

The third dependent variable to yield significant results was the one related to healthy coping attitudes for dealing with an

alcoholic parent. The cognitive group displayed a significant ($p < .05$) increase in healthy coping attitudes both immediately following counseling and at the two-month follow-up. A similar posttest trend was reported for the experiential group, but post-posttest findings failed to support the earlier trend. Not only was the cognitive group able to effect changes in attitudes in this area, but the effect was a lasting one.

The last major finding to emerge from this study was produced by the experiential group. Posttest results showed a significant ($p < .05$) increase in healthy coping behaviors for dealing with an alcoholic parent by the experiential group. There was also a marginally significant trend in this same direction for the experiential group compared to the cognitive group. Data gathered at the two-month follow-up stage indicated only a marginally significant trend in the direction of higher scores on this subscale by the experiential group in comparison with the other two groups. Given the fact that the cognitive group was superior to the experiential group in terms of its ability to effect attitude change, it came as somewhat of a surprise to see the experiential group surpass the cognitive one on the variable measuring behavior change.

The traditional knowledge-attitude-behavior (k-a-b) model operates under the basic assumption that behavior change is the logical outcome of a linear sequence involving atittude change which is in turn preceded by an increase in knowledge. The findings of

this study challenge this simplistic and slightly antiquated model. Contrary to what the k-a-b model would predict, the experiential group in this study demonstrated immediate improvement in healthy coping behaviors in the absence of seemingly prerequisite attitude changes. Perhaps the difficulty experienced by the experiential group in sustaining the initial improvement in healthy coping behaviors is at least partially attributable to the lack of a solid foundation in the form of healthier coping attitudes.

The only significant difference to appear between experimental groups involved higher levels of knowledge about alcohol use in the cognitive group than in the experiential group two months after treatment ($p < .05$). However, a comparison of experiential and cognitive group means revealed some interesting findings. The two were similar on the Quantity-Frequency Index of alcohol consumption, responsible attitudes toward drinking, and knowledge about alcoholism and its effects on the family. The cognitive group scored consistently higher than the experiential group on healthy coping attitudes and on knowledge about alcohol. This group rated consistently lower than the experiential one on healthy coping behaviors and the negative behavioral consequences of alcohol abuse.

At first glance, this study appears to have generated a rather confusing collection of disjointed findings. The application of inductive reasoning to the process of clarifying and interpreting these results makes this challenging task a manageable one. The most

obvious conclusion to emerge is that each of the experimental treatment groups possessed unique strengths as well as weaknesses. The cognitive group was able to produce increases in knowledge levels and some attitudinal changes, but the absence of an experiential component represented a gap in terms of implementing behavior change. The cognitive group was unsuccessful in translating healthy coping attitudes into healthy coping behavior skills. Conversely, the experiential group was able to generate some immediate behavioral changes; however, the lack of success they experienced in sustaining them may be traced to this group's inability to develop healthy coping attitudes to support the effected behavior change.

Informal feedback received from participants indicated an overwhelmingly positive reaction to the group experience. This is consistent with the high degree of involvement, cooperation, and participation demonstrated by the vast majority of subjects in this research project. Those in the two experimental groups expressed a strong desire for more time for personal sharing and support. While acknowledging the value and need for the highly structured, educational emphasis of the group counseling experience, the clear consensus among students was that the format would have better suited their needs had it provided greater opportunity for more intimate, unstructured contact among group members.

In retrospect, it seems obvious that in explicitly designing a highly structured agenda aimed at attaining educational

objectives, the writer may have erred in underestimating the intensity of the emotional reactions that were concomitants of cognitive understanding. Direct evidence to substantiate this observation comes from two sources. First, several participants in the experimental treatment groups voiced a strong desire to be included in any type of supportive/therapy group that might be made available to children of alcoholics at the Counseling Center at some later date. A second indication of the emotional impact of the educational group counseling is the fact that a number of participants elected to become involved in individual counseling concurrently with their group experience.

Several comments regarding the groups and the group process are especially relevant to this discussion. In terms of group composition, there was a striking balance in numbers of men and women in each of the experimental groups; the author/leader observed that this sexually heterogeneous blend seemed to be an important factor contributing to the warm, relaxed atmosphere that permeated the groups. Another element, which seemed to contribute significantly to rapport building within the groups, was the writer/leader's self-disclosure concerning his personal experiences as the child of an alcoholic mother. Not only was this strong sense of emotional closeness evidenced in each of the groups, but it developed with extraordinary quickness.

The author's basic assumption that participants entertained numerous misconceptions concerning their parent's alcoholism received

strong confirmation. This served to reinforce the earlier planning decision to place a top priority on the attainment of cognitive awareness. While it had been anticipated that emotional awareness would follow cognitive awareness, it was not expected that emotional responses would rise so rapidly to the surface. Reflecting back on the process, several factors may have been contributory. The group served as an outlet for a strong need to share experiences and to ventilate some powerful, repressed emotions. Similar to other children of alcoholics in terms of feeling isolated and somewhat alienated by virtue of their parent's stigmatized illness, these students expressed a tremendous sense of relief and comfort in realizing that they were not alone. By having the opportunity to be heard and to feel understood by the group, it made it easier for individuals to acknowledge and begin to accept hitherto neglected emotional needs. Part of the heavy burden of being the child of an alcoholic was relieved in the sharing process, and the group context was conducive to legitimizing the existence of their own unattended emotional concerns. As group leader and also the offspring of an alcoholic, it was an extremely rewarding experience to witness the process of intensely personal, important needs beginning to find fulfillment.

During the course of conducting this investigation, it soon became apparent that the topic was an extremely sensitive one of compelling interest to members of the university community. There

was a strong response from all of the local media. This rapid and brief flurry of attention represented more than a reflex reaction to a "hot" topic. The media bandwagon underscored and confirmed the absence of attention characteristically given to the special concerns of the offspring of alcoholics. On the positive side, the efforts of the local press did contribute to a raising of the general level of consciousness regarding this topic. More specifically, an article that appeared on the front page of the University of Florida's daily student newspaper, the Alligator, was directly responsible for some of the students enrolling in the experimental groups. Staff at the Counseling Center were also made aware of the groups, and they made a number of direct referrals from their caseloads.

Other students who chose to participate in the study learned about the educational group counseling as a result of hearing the writer deliver a minilecture on children of alcoholics; as mentioned earlier, this presentation was made to classes in both alcohol use and abuse as well as introductory psychology and personal growth. This outreach approach not only ensured that a large number of students would learn of the counseling groups, but it also served the important function of making the group leader visible in a personal way.

A few constructive comments concerning the experimental groups are in order before bringing this discussion to an end. Two major questions need to be addressed: (1) What seemed to be the

strongest features of each of the two experimental treatment groups? (2) Did either Al-Anon or Alateen represent a more appropriate resource than the structured counseling groups for university students of alcoholic parentage that participated in this study?

Informal feedback from participants indicated that two components of the cognitive group approach had a special impact. These were the movies and the guest speakers; in particular, the speaker from Al-Anon and the movies, Soft is the Heart of a Child and If You Loved Me, exerted the most widespread and powerful influence. The site visits and role plays stood out as the most meaningful features of the experimental group approach.

While student comments concerning their attendance at an Al-Anon meeting were generally favorable, a major drawback was consistently mentioned. It seems that the overwhelming majority of regular Al-Anon group members in Gainesville were spouses of alcoholics. Several were also children of alcoholics, but their status as spouse was clearly the focus of the meetings. Additionally, the mean age of the Al-Anon meetings was much higher than the average age of university students in the counseling groups. A few members of the experiential group objected to the spirtual basis of the Al-Anon meetings and/or their somewhat simplistic, unsophisticated approach, but most felt that Al-Anon had a great deal to offer family members of alcoholics. As noted earlier, there was no local Alateen meeting to attend, but it seems safe to assume that the

mean age of Alateen members would be quite a bit less than the average age of the students in this study. In addition to perhaps being somewhat on the juvenile side, it is questionable how much overlap there would be between the needs of adolescents living on a daily basis with their alcoholic parent and the slightly different concerns facing more independent, mature university students. In summary, this study uncovered a definite gap in terms of the populations best suited for service from Alateen and Al-Anon. The special needs and concerns of university students of alcoholic parentage are without a functionally appropriate resource in the local community.

Conclusions

1. Neither the cognitive nor the experiential treatment approach produced a significant decrease in the Quantity-Frequency Index of alcohol consumption either immediately or after two months of treatment. However, suggestive evidence revealed that for high Q-F pretest indices, both the experiential and cognitive treatment groups yielded lower pretest scores than the control group immediately following treatment.

2. The cognitive group produced significant increases in knowledge about alcohol in comparison to both the experiential group and the control group two months after treatment. There was evidence suggestive of this trend immediately following treatment, but significant effects only appeared in the follow-up data.

3. Neither experimental approach produced significant increases in levels of responsible attitudes toward alcohol use either immediately or two months after treatment.

4. Posttest and post-posttest results showed that neither the cognitive nor the experiential group produced a significant reduction in negative behavioral consequences experienced as a result of drinking. However, the evidence was suggestive of a trend in that direction by both experimental approaches at the two-month follow-up.

5. The cognitive group and the experiential group each demonstrated a significant gain in knowledge about alcohol and its effects on the family immediately following completion of counseling. Evidence of this change was only suggestive and not significant two months after treatment.

6. The cognitive group evidenced a significant increase in healthy coping attitudes toward parental alcoholism, and this effect was both immediate and lasting over two months. The data were suggestive of a similar trend in the experiential group immediately following treatment, but no evidence supportive of this earlier trend materialized at the two-month follow-up.

7. Posttest data indicated that the experiential group demonstrated a significant increase in healthy coping behaviors for dealing with an alcoholic parent. There was also evidence of a marginally significant trend in this same direction by the

experiential group in comparison to the cognitive group, but none of these immediate effects reappeared at the two-month follow-up.

8. In comparison to the cognitive group, the experiential group consistently displayed lower means of incidences of negative behavioral consequences of drinking as well as lower means of coping attitudes toward parental alcoholism; however, these differences were not statistically significant.

Implications

The findings of this study contain numerous implications for educators, student mental health service providers, counseling center staff members, and other university personnel concerned with: (1) addressing the special needs of university students of alcoholic parentage, and (2) secondary prevention efforts aimed at reducing future alcohol abuse among this vulnerable, high-risk subpopulation.

1. University students who are children of alcoholic parents constitute an isolated yet identifiable subpopulation within the university community. The interest exhibited by the participants in this investigation is compelling evidence that a need exists for special services tailored specifically to meet their unique concerns.

2. Interest displayed by the media provided yet another significant (albeit indirect) indication of a need existing. However, it required difficult work to get this need translated into demand, and prospective service providers in this area are confronted with

a formidable task demanding creative, cooperative efforts. In addition to educationally oriented consciousness raising, successful translation of need into demand requires campus-wide involvement at various levels. Successful outreach efforts are critical in this regard. Student self-identification and self-referral are an obvious goal, but outreach must also concern itself with equipping key university personnel with skills enabling them to successfully identify and refer students of alcoholic parentage for counseling help.

3. In keeping with the aforementioned importance of strengthening all available means of identification and referral, there is the clearcut need to locate an advocate who will secure the commitment from some university organization to provide a viable resource on campus for students of alcoholic parentage. Al-Anon is a logical place to begin the search for such an advocate. A person who is emotionally committed to this kind of project is likely to generate the high degree of personal enthusiasm that seems to be an indispensable prerequisite for the successful mobilization of campus support.

4. Obstacles to the establishment of a counseling group for university students from alcoholic families are many and not to be underestimated. Publicity and media support in the form of newspaper articles, radio and t.v. slots, etc. are invaluable aids. Children of alcoholics are represented in alcohol education classes

in disproportionately large numbers; so, these places are a logical starting place for direct efforts to attract prospective group members. Due to the stigma still attached to the disease of alcoholism, anything that might help legitimize participation in counseling for this difficult-to-identify and reluctant-to-self-refer group is well worth the effort. For example, somehow arranging for course credit to be earned through participation in group counseling might make it easier and/or give potential members an excuse to become involved. Starting counseling groups from scratch for this subpopulation of students is extremely difficult as well as both energy- and time-consuming; however, if this part of the project is planned thoughtfully and executed thoroughly, then the chances are excellent that sufficient numbers of interested students will make viable the goal of starting such a group.

5. Assuming that there are enough students interested in joining a group for children of alcoholics, the most important considerations in formulating the actual design revolve around the twin objectives of maximizing relevance to student needs and of maximizing the prospect for continuity of the group as an on-campus resource for children of alcoholics. Aside from providing a healthy blend of education and support, a successful counseling group in a university setting draws its greatest strength from its college-age, peer membership. This would present an attractive alternative to both Al-Anon and Alateen in terms of the age variable, and it would also be likely

to attract those students to whom Al-Anon is unappealing for other reasons alluded to previously.

6. In the event that the necessary energy and/or resources are not present in sufficient quantity to establish a university-supported counseling group for students of alcoholic parentage, an option would be to try to establish an Alateen group on campus. An educational, structured group might be offered as a supplement to Alateen in order to provide students with the opportunity for exposure to some of the research and literature that fall outside the scope of Alateen.

Recommendations for Future Research

1. A review of the literature as conducted by this writer makes it evident that little emphasis has been placed on the idea of providing group counseling tailored specifically to the special needs of university students with an alcoholic parent. The present pioneering study furnishes a model of a structured, educational counseling effort which has shown to be effective. In addition to direct replication of this study, other researchers might add a third experimental treatment group that represents a mixture of the best features of both the cognitive and experiential approaches. Similar findings on other campuses would serve to strengthen the argument for the effectiveness of this type of program.

2. The experiences encountered in this investigation make it abundantly clear that the highly structured, educational approach

to group counseling has some shortcomings. The educational emphasis was successful in its efforts to increase cognitive awareness, but it failed to provide participants with a sufficient amount of unstructured time for group processing of content issues and for personal sharing and support. This problem could be remedied by extending the total number of sessions, thereby freeing time for sharing/supporting/processing during each session. A second alternative would be to continue the structured group counseling as outlined here and follow it up with an open therapy/support group; participation in the structured counseling could be used as a prerequisite for joining the therapy/support group. In addition to serving as a less threatening prelude to the therapy/support group, the structured counseling would provide members with a solid, well-informed understanding of important concepts relevant to being the child of an alcoholic. Lastly, the educational counseling group could function as a screening device for later participation in the therapy/support group.

3. Researchers need not feel in any way constrained by the guidelines adhered to in this investigation. More evaluative research should be conducted on the effectiveness of a variety of imaginative efforts aimed at secondary prevention for this vulnerable subpopulation of students. Different combinations of approaches must be tested in order to discover the optimal format for counseling groups.

4. The present research project examined follow-up data collected two months following completion of the counseling. Two months may represent too brief a time period from which to evaluate the lasting effects of treatment. Although a six-month or one-year follow-up study would pose a number of logistical problems due to student mobility, it would furnish more convincing evidence of lasting treatment effects.

5. Future researchers in this area would be well-advised to conduct a thorough needs assessment among this population of students. In addition to identifying the total number of students of alcoholic parentage, information gathered from such an undertaking would be invaluable in providing input relevant to the task of planning a counseling group best suited to participant needs. Though costly in terms of time, needs assessment interviews of a random sample of students with an alcoholic parent would produce a rich source of useful information.

6. Future research in this field should seriously consider the idea of employing interviews as an additional assessment tool along with the measurement instruments used in the present study. Student level of denial concerning the parent's alcoholism and its effect on his/her life is an important yet extremely difficult variable to measure; a well-conceived interview would be an excellent way to monitor any changes in this key area. Also, interviews conducted subsequent to completion of treatment would shed light on the aspects of the group process most relevant to positive change.

7. Assuming the availability of a sufficiently large sample of students, it would be interesting to compare the effectiveness of treatment provided by a counseling group sponsored by the university vis-a-vis Alateen or Al-Anon.

8. Future research of a far more ambitious nature might focus on the effects of a therapy/support counseling group and/or educational group counseling on some personality variables. Ziller (1973) provides an interesting and creative perspective from which to view personality change together with unobtrusive measures of his self-other orientations (e.g., self-esteem, social interest, marginality, self-centrality, openness, etc.).

9. Many college campuses already offer alcohol education classes. Characteristically, these courses devote very little attention to the topic of alcoholism and its effects on the family. It would be worthwhile to compare the effectiveness of a college-level course on alcohol education with a structured counseling group aimed specifically at the unique concerns of students of alcoholic parentage. In particular, it would be important to evaluate and compare the effects of each on the student's knowledge, attitude, and behavior with regard to alcohol use. Results of such a comparison might strengthen the rationale for special secondary prevention efforts targeted for students with alcoholic parents.

In summary, the present study has demonstrated that educational group counseling can produce desired changes in knowledge about

alcohol use as well as in knowledge, attitudes, and behavior related to alcoholism and its effects on the family. This type of counseling is an effective tool of secondary prevention for this vulnerable, high-risk subpopulation of students. This program of structured group counseling represents an innovative approach, and the results are extremely encouraging. Corroboration by other researchers could help stimulate the growth of effective group counseling services on campuses throughout the country for those university students that are the neglected, secondary victims of parental alcoholism.

APPENDIX A
CRITERIA FOR PARENTAL ALCOHOLISM*

		YES	NO
1.	Do you lose sleep because of someone's drinking?	____	____
2.	Do you think a lot about problems that arise because of that person's drinking?	____	____
3.	Do you ask for promises to stop drinking?	____	____
4.	Do you make threats?	____	____
5.	Do you have increasing bad feelings toward the person?	____	____
6.	Do you want to throw away his or her liquor? Or hide it?	____	____
7.	Do you think that everything would be okay if the drinking situation changed?	____	____
8.	Do you feel alone, rejected, fearful, angry, guilty, exhausted?	____	____
9.	Are you feeling an increased dislike of yourself?	____	____
10.	Do you find your moods changing as a direct result of his or her drinking?	____	____
11.	Do you try to deny or conceal the drinking situation from friends?	____	____
12.	Do you cover for and protect the person?	____	____
13.	Do you feel responsible and guilty for the drinking behavior?	____	____
14.	Are you beginning to withdraw from friends and outside activities?	____	____
15.	Have you taken over responsibilities that used to be handled by the other person?	____	____

		YES	NO
16.	Are there arguments because too much money is spent on drinking?	____	____
17.	Do you find yourself trying to justify the way you feel and act in reaction to the drinking problem?	____	____
18.	Do you have any new physical symptoms like headaches, indigestion, nausea, shakiness?	____	____
19.	Do you feel defeated and quite hopeless?	____	____
20.	Is you school work suffering because of the drinking problem?	____	____

For the purposes of this study, any student who answers "Yes" to three or more of the above questions will be assumed to have a parent who is (was) an alcoholic.

*Criteria are from "20 Questions. A Serious 'Game' About Drinking" by Operation Cork. These questions are a revision of questions developed by Betty Reddy, Program Specialist: Alcoholism Treatment Center, Lutheran General Hospital, Park Ridge, Illinois.

APPENDIX B
INFORMED CONSENT FORM

EXPERIENTIAL GROUP

This educational counseling group for students with one or more alcoholic parents will consist of five consecutive weekly sessions, with each lasting 2 hours. The group will be conducted via an experimental method, and the following concepts will be covered: alcohol, alcoholism and treatment, alcoholism and the spouse, alcoholism and the children, childhood coping patterns, healthy coping attitudes and behaviors, responsible behavior toward alcohol, and responsible drinking.

Students may be asked to attend an "open" Alcoholics Anonymous meeting, visit an alcoholism treatment center, attend an Al-Anon meeting, participate in role-playing exercises, attend a demonstration cocktail party, and engage in expressive drawing. Any student who experiences any discomfort in taking part in any of the above activities or who cannot participate for religious or other reasons will be given an optional learning experience. No one will be required or pressured to drink at the responsible drinking party.

The potential benefits of this experience will be increased understanding of the disease of alcoholism and its implications for the family; also, improved self-awareness and personal growth are possible; other conceivable benefits include an improved ability to cope with present and/or future problems related to the parental drinking problem. There will be no monetary compensation involved.

I will be glad to answer any questions you might have about the above guidelines for the group, and, as group leader, I will be available to deal with any further questions that might arise. Any personal material disclosed within the group will be held in strict confidentiality. If you agree to participate, then you will be free to withdraw consent and discontinue at any time without prejudice. Your participation will include filling out some self-report questionnaires (anonymously).

I have read and understand the procedure described above. I agree to participate, and I have received a copy of the description.

Signed: _____ _____
Student Witness

Date_____ Date_____

Principal Investigator: Harry F. Klinefelter, 102 N.W. 32nd Street, Gainesville, FL 32607. Phone: 375-4632

APPENDIX B
INFORMED CONSENT FORM

COGNITIVE GROUP

This educational counseling group for students with one or more alcoholic parents will consist of five consecutive weekly sessions, with each lasting 2 hours. The group will be conducted via an experimental method, and the following concepts will be covered: alcohol, alcoholism and treatment, alcoholism and the spouse, alcoholism and the children, childhood coping patterns, healthy coping attitudes and behaviors, responsible behavior toward alcohol, dealing with alcohol problems, and responsible drinking. Group time will be spent viewing films, listening to speakers, and then discussing the various concepts.

The potential benefits of this experience will be increased understanding of the disease of alcoholism and its implications for the family members; also, improved self-awareness and personal growth are possible; other conceivable benefits include an improved ability to cope with present and/or future difficulties related to the parental drinking problem. There will be no monetary compensation involved.

I will be glad to answer any questions you might have about the above guidelines for the group, and, as group leader, I will be available to deal with any further questions that might arise. Any personal material disclosed within the group will be held in strict confidentiality. If you agree to take part, then your participation will include filling out some self-report questionnaires (anonymously). You are free to withdraw consent and discontinue at any time without prejudice.

I have read and understand the procedure described above. I agreed to participate, and I have received a copy of the description.

Signed: _____ _____
Student Witness

Date_____ Date_____

Principal Investigator: Harry F. Klinefelter, 102 N.W. 32nd Street, Gainesville, FL 32607. Phone: 375-4632

APPENDIX C
OUTLINE FOR EXPERIENTIAL GROUP*

Week	Concept	Implementation
1	Alcohol, Alcoholism, and Treatment	Introduction, Site Visit to Either (1) Local Detoxification Center, (2) Local VA Hospital Alcohol Treatment Program, or (3) "Open" Alcoholics Anonymous Meeting, Literature
2.	Alcoholism and the Spouse	Process Site Visits of Previous Week, Site Visit to Local Al-Anon Meeting, Literature
3	Alcoholism and the Children; Childhood Coping Patterns	Process Site Visit to Al-Anon Meeting, Role Play Alateen Meeting, Minilecture by Leader on Childhood Coping Patterns, Expressive Drawing of Childhood Methods of Coping, Pamphlets
4	Healthy Coping Attitudes and Behaviors	Lecture, Role Play Situations Involving Various Ways of Coping with Alcoholic Parents, Literature
5	Responsible Behavior Toward Alcohol; Responsible Drinking	Role Play Situations Involving Issue of Responsible Drinking, Responsible Drinking Party, Pamphlets, Wrap-up and Final Processing and Sharing of Feedback

*Pretesting materials were completed during the week prior to the first group meeting. Individuals were given the pretest measures following an individual screening interview with the group leader. Posttesting materials were distributed at the final (fifth) session, and group participants were asked to fill in the questionnaires and return them within a few days.

APPENDIX D
ROLE PLAY VIGNETTES:
HEALTHY COPING ATTITUDES AND BEHAVIORS

Joan, John and Debby are home from college on vacation. When they come in the house, their alcoholic father is alone and has obviously been drinking heavily. Joan feels like leaving and going to a movie or a friend's house. John wants to stay, play some pool and watch TV, leaving their father alone upstairs in the living room. Debby wants to yell at her father for drinking so much; she wants to persuade him to stop, for the family's sake. If this approach fails Debby plans to force him to stop drinking by hiding the bottle.

Sally and Mary are sisters who go to the same college. They are on vacation and have just come back home after a party. They see their alcoholic mother passed out and lying in a messy heap on the living room floor. Sally wants them to help their intoxicated mother get to bed and then clean up the mess, but Mary thinks it would be wiser to leave her mother exactly where she is and let their mother wake up and find herself exactly as Mary and Sally found her.

Steve and Doug are back from college on vacation. A week ago, their alcoholic father promised the family that he'd stop drinking. So far, so good. They came home tonight and can tell that he has been drinking. Both Steve and Doug are understandably disappointed. Steve gets angry; he wants to yell at and blame his father for breaking his promise not to drink; he asks his Dad what he (Steve) has to do to get him to stop drinking. He tries to get his father to make another promise. Doug talks to Steve after this little episode. Doug tries to convince Steve that it is better not to accept, much less extract such promises not to drink; Doug knows it is pointless for him to try to control his father's drinking.

Mr. Smith got drunk last night. He didn't plan to keep drinking until he passed out, but he lost control. This morning he has a hangover and is feeling very guilty. His children, Bill, Jane and Betty come to the breakfast table still upset about how their father got drunk again last night. Jane is angry and gives her Dad the silent treatment. Bill gets into an argument with his father by trying to convince him that he's an alcoholic. Betty wishes she could be alone with her father so she could discuss specific behaviors of his when he's drunk and let him know how much his drinking hurts her.

Their mother's drinking problem has gotten steadily worse. One day, Pete, Joe, Mary and Donna discuss what they'd like to do about it. Pete, the oldest, just wants to get away from it all and pretend that it doesn't exist. He can't wait until he finishes high school and leaves for college. Joe, the youngest, thinks they ought to do something about the situation by getting some kind of help, but he would feel guilty (as if he'd somehow betrayed his Mom) about letting anybody outside the family know about his mother's drinking problem. Mary is the eldest daughter, but she's too embarrassed to look for outside help (besides, her mother says she's not an alcoholic). Donna has a friend whose father is an alcoholic. This friend told her about Alateen. She thinks they should go to an Alateen meeting to see if that might help them with the problem.

Mary is a college student home on break. Her younger sisters, Pam and Judy, complain about how grouchy and strict their mother is compared to their father (he's the alcoholic). Mary tries to explain to them how hard their Dad's drinking makes it for their Mom to be in a good mood. Mary says their mother only seems so strict because their Dad's drinking keeps him from enforcing family rules.

APPENDIX E
ROLE PLAY VIGNETTES:
RESPONSIBLE BEHAVIOR TOWARD ALCOHOL

Sally and Joanne would like to have a party at their apartment. They asked their boyfriends, Tom and Bill, to help make plans. Bill and Sally think a good party is when everyone gets drunk and rowdy. Joanne and Tom, though, think everyone should be able to have fun without getting drunk or even without drinking.

Joe has a tendency to drink too much once he gets started. He is at a party and is trying to drink moderately because he has an important interview tomorrow. He is proudly explaining to his girlfriend what measures he has already taken to avoid getting drunk when his roommate tries to get him to join a chugging contest. He hesitates because he always does well in these contests and likes the social praise he receives.

John and his friends are planning to go out to a few bars and have a good time drinking. They don't want to worry about driving after drinking so they get together and try to come up with some ideas about how they can get home safely and still have fun.

Two three-person debate teams are addressing the issue of alcohol education. Side A advances the argument that alcohol education should focus on presenting only the facts about alcohol. Side B argues that education should focus on how to drink responsibly.

(Rozelle, 1978)

APPENDIX F
SCHEDULE OF FILMS

Week 1: Chalktalk - Father Joe Martin delivers classic lecture on alcohol (its physical and psychological effects), alcoholism, and recovery.

Week 2: If You Loved Me - focuses on the wife's attempts to cope with her husband's alcoholism.

Week 3: Soft is the Heart of a Child - portrays the struggle experienced by children living with an alcoholic parent; shows how they obtain help.

Week 4: Booze and Yous - deals with the issue of responsible drinking.

APPENDIX G
VALUES CLARIFICATION

In America we do not have a consensus as to what constitutes responsible drinking behavior. This, then, leads to controversy and confusion regarding the definition of problem drinking and standards of responsible drinking.

Please rank the following examples from: most responsible drinking behavior (1)--to--least responsible drinking behavior (8). Then within your group, please discuss your ranking and arrive at a consensus ranking.

Sheryl and Jim enjoy each other's company a lot. They sometimes enjoy going out dancing at a bar. When they drink, although Sheryl reaches her limit before Jim, she doesn't like to refuse Jim's offer of another round.

When Jackie throws a party she goes all out. There's always good food and plenty of beer and wine, but she also served nonalcoholic beverages for those who choose not to drink.

After a hard day's work, George usually comes home and has a few drinks in order to relax.

Amy likes to have a good time at parties and she enjoys drinking even though she doesn't go to a party just to drink but also to see friends and to have a good time. Drinking to her is one way of enhancing some of her social activities but is not the focus of these activities.

Pete doesn't drink all that often but when he does, he really ties one on.

Hitting the bars is one of John's favorite weekend pastimes, but he knows his limit and tries to stick to it. John knows how much alcohol he can handle and still drive safely.

Carl has missed four classes this quarter because he has been really hung over. His grades have started to suffer and Carl has decided to do something about his excessive drinking.

Jerry likes everybody to have a good time at his parties, but he is never insistent about refilling drinks. In fact, Jerry will express displeasure if he feels that a person has had too much to drink.

(Gonzalez, 1978)

APPENDIX H
OUTLINE FOR COGNITIVE GROUP*

Week	Concept	Implementation
1	Alcohol, Alcoholism, and Treatment	Film (see Note 1), Guest Speaker from Local Community Alcohol Program, Discussion, Pamphlets
2	Alcoholism and the Spouse	Film (see Note 2), Discussion, Pamphlets
3	Alcoholism and the Children; Childhood Coping Patterns	Film (see Note 3), Guest Speaker from Al-Anon, Discussion, Pamphlets
4	Healthy Coping Attitudes and Behaviors	Minilecture by Leader, Guest Speaker from Counseling Center, Discussion, Pamphlets
5	Responsible Behavior Toward Alcohol; Responsible Drinking	Film (see Note 4), Guest Speaker from Campus Alcohol Information Center, Values Clarification, Discussion, Pamphlets, Wrap-up

*Pretesting took place during the week prior to the initial group meeting; students were given the pretest measure following an individual screening interview with the group leader. Posttesting materials were handed out at the last group session, and participants were instructed to fill in the questionnaires and return them within a few days.

APPENDIX I
STUDENT DRINKING INFORMATION SCALE

Instructions: Choose your response for each question and indicate the appropriate answer on this questionnaire. Your cooperation will be greatly appreciated.

SECTION I

1. How old are you?

2. Sex: a. female b. male

3. Race: a. Caucasian b. Black c. Hispanic d. Oriental 3. American Indian f. Other

4. What is your marital status? a. single b. married c. separated d. divorced e. widowed

5. Religious preference: a. Methodist b. Mormon c. Jewish d. Episcopalian e. Catholic f. Baptist g. Presbyterian h. Other (please specify)

6. What is your school classification? a. freshman b. sophomore c. junior d. senior e. graduate student

7. Place of residence: a. university residence halls or other university housing b. fraternity house c. sorority house d. off-campus apartment or other private residence e. parents' home

8. When you were in high school, did your close friends drink alcoholic beverages? a. never b. sometimes c. often d. all the time e. don't know

9. When you were in high school did your mother drink? a. never b. sometimes c. often d. all the time e. don't know

10. When you were in high school, did your father drink? a. never b. sometimes c. often d. all the time e. don't know f. not applicable

11. Have you ever drunk an alcoholic beverage? a. never have b. previously, but not at present c. currently drink

(IF THE ANSWER TO QUESTION #11 IS EITHER "a" OR "b", SKIP TO SECTION VIII)

SECTION II

12. How old were you when you took your first drink? a. elementary school age b. junior high/middle school age c. high school age d. college age

13. Did your parents know you had tried alcohol? a. yes b. no c. not sure

14. Where were you when you took your first drink? a. at home b. at a friend's home c. at a bar d. at a school function e. other (specify)

15. What alcoholic beverage do you usually drink? a. beer b. wine c. mixed drinks d. straight liquor

16. If you drink beer, how many 12 oz. cans do you usually have at one sitting? a. do not drink beer b. 1 or less c. 2-3 d. 4-5 e. 6 or more

17. If you drink wine, how many 6 oz. glasses do you usually have at one sitting? a. do not drink wine b. 1 or less c. 2-3 d. 4-5 e, 6 or more

18. If you drink mixed drinks with 1 oz. shots of alcohol in them, how many drinks do you usually have at one sitting? a. do not drink mixed drinks b. 1 or less c. 2-3 d. 4-5 e. 6 or more

19. If you drink straight liquor, how many 1 oz. drinks do you usually have at one sitting? a. do not drink straight liquor b. 1 or less c. 2-3 d. 4-5 e. 6 or more

20. How often do you usually drink? a. once a month or less b. 2 or 3 times a month c. once a week d. two times a week e. three times a week f. four or more times a week

21. When you drink, where do you usually drink? a. at home b. at a bar or lounge c. in the residence hall d. at a fraternity/sorority house e. at a friend's place e. other

22. Do you drink alone? a. never b. sometimes c. frequently

23. Do you feel there are enough adequate, healthy alternatives to drinking-oriented activities on this campus? a. yes b. no c. not sure

SECTION III

INDICATE IN THE FOLLOWING QUESTIONS IF THE FOLLOWING SITUATIONS INFLUENCE YOU TO INCREASE YOUR CONSUMPTION OF ALCOHOLIC BEVERAGES AT PARTIES AND OTHER SOCIAL FUNCTIONS.

24. Too many people in the room. a. yes b. no

25. The lack of alternative non-alcoholic beverages available. a. yes b. no

26. Drinking games or contests. a. yes b. no

27. A host or hostess who constantly offers to refill drinks. a. yes b. no

28. The presence of a bartender or someone in charge of serving drinks. a. yes b. no

SECTION IV

When you drink, why do you usually drink?

29. For escape from daily problems or school. a. yes b. no

30. To facilitate studying. a. yes b. no

31. To relax and have fun. a. yes b. no

32. To impress your dates. a. yes b. no

33. For the taste. a. yes b. no

34. To get high or drunk. a. yes b. no

35. Because it is expected by peers. a. yes b. no

SECTION V

IN THIS SECTION WE WOULD LIKE TO ASK YOU SOME INFORMATION ABOUT ALCOHOL. THE QUESTIONS WILL EITHER BE TRUE or FALSE. IF YOU DO NOT KNOW THE ANSWER TO THE QUESTION DO NOT GUESS. CIRCLE THE LETTER CORRESPONDING TO DON'T KNOW.

36. Eating before drinking an alcoholic beverage will slow the absorption of alcohol into the body.

a. True b. False c. Don't Know

37. A blood alcohol concentration of 0.1% is the legal definition of alcohol intoxication in most states in regards to driving.

    a. True b. False c. Don't Know

38. Alcohol is classified as a stimulant drug.

    a. True b. False c. Don't Know

39. Approximately 20% of fatal highway accidents are alcohol related.

    a. True b. False c. Don't Know

40. A person cannot become an alcoholic by just drinking beer.

    a. True b. False c. Don't Know

41. Excessive drinking alcoholic beverages during pregnancy may cause mental retardation and other abnormalities in the fetus.

    a. True b. False c. Don't Know

42. It takes about as many hours as the number of drinks consumed to completely burn up the alcohol ingested.

    a. True b. False c. Don't Know

43. Proof on a bottle of liquor represents twice the percent of alcohol contained in the bottle.

    a. True b. False c. Don't Know

44. Drinking coffee or taking a cold shower can be an effective way of sobering up.

    a. True b. False c. Don't Know

45. Champagne and sparkling wines are absorbed more slowly than non-carbonated drinks.

    a. True b. False c. Don't Know

46. A 12-ounce can of American beer contains about 4 percent pure alcohol.

    a. True b. False c. Don't Know

47. A one-ounce shot of whiskey contains the same amount of pure alcohol as a 4-ounce glass of table wine or a 12-ounce can of beer.

    a. True b. False c. Don't Know

SECTION VI

THE STATEMENTS THAT FOLLOW REFER TO THE USE OF ALCOHOL. PLEASE THINK ABOUT EACH ONE AND THEN CIRCLE THE LETTERS CORRESPONDING TO HOW LIKELY YOU ARE TO ACT THAT WAY: a. very likely, b. likely, c. somewhat likely, d. unlikely, e. very unlikely

How likely are you to:

48. Always use alcohol as an adjunct to an activity rather than as the primary focus of attention.

    a. VL b. L c. SL d. U e. VU

49. Rationalize drinking behavior by such comments as "I just need one more to relax" or "how about one for the road."

    a. VL b. L c. SL d. U e. VU

50. Provide non-alcoholic alternative drinks; fruit juices, unspiked punch, coffe, or tea at your party.

    a. VL b. L c. SL d. U e. VU

51. Set limits on how many drinks you are going to have a night out or at a party.

    a. VL b. L c. SL d. U e. VU

52. Gulp drinks for the stronger effect that rapid drinking produces.

    a. VL b. L c. SL d. U e. VU

53. Respect a person who chooses to abstain from drinking alcohol.

    a. VL b. L c. SL d. U e. VU

54. Drink alone from a desire to escape boredom or loneliness.

    a. VL b. L c. SL d. U e. VU

55. Not be insistent about "refreshing" or refilling drinks.

    a. VL b. L c. SL d. U e. VU

56. Tell a friend that there is nothing funny about being drunk when he or she is bragging about their drinking.

    a. VL b. L c. SL d. U e. VU

57. Seriously think about the problems of alcohol abuse.

    a. VL b. L c. SL d. U e. VU

58. Talk about how to use alcohol responsibly with your roommate or close friend.

    a. VL b. L c. SL d. U e. VU

59. Express displeasure to someone who has had too much to drink at your party.

    a. VL b. L c. SL d. U e. VU

60. Provide transportation or overnight accommodations for someone who is unable to drive safely after drinking at your party.

    a. VL b. L c. SL d. U e. VU

61. Always celebrate by drinking when things go well for you.

    a. VL b. L c. SL d. U e. VU

62. Provide food whenever you're hosting a party or social event where alcohol is being served.

    a. VL b. L c. SL d. U e. VU

63. Discourage a date or friend who is under the influence of alcohol from driving.

    a. VL b. L c. SL d. U e. VU

64. Get involved in trying to help a friend or associate who has a drinking problem.

    a. VL b. L c. SL d. U e. VU

65. Drink alcohol primarily to get drunk.

    a. VL b. L c. SL d. U e. VU

66. Know and stay within your personal drinking limit based on body weight if you are going to drive.

    a. VL b. L c. SL d. U e. VU

67. Seek help if you thought you had a drinking problem.

    a. VL b. L c. SL d. U e. VU

SECTION VII

TO THE BEST OF YOUR RECOLLECTION, INDICATE THE EXTENT TO WHICH YOU HAVE EXPERIENCED THE FOLLOWING COMMON RESULTS OF DRINKING DURING THE PAST TWO MONTHS.

a. Never b. Once c. Twice d. Three times e. Four times f. Five times or more

68. I have had a hangover.

69. I have gotten nauseated and vomited from drinking.

70. I have driven a car after having had several drinks.

71. I have driven a car when I knew that I had too much to drink.

72. I have drunk while driving.

73. I have cut a class after having several drinks.

74. I have gone to class after having several drinks.

75. I have missed a class because of a hangover.

76. I have been arrested for DWI (Driving While Intoxicated).

77. I have been criticized by an associate because of drinking.

78. I have received a lower grade as a consequence of drinking too much.

79. I have gotten into a fight after drinking.

80. I have thought on occasion that I might have a drinking problem.

81. I have damaged property, pulled a fire alarm, or other such actions after drinking.

82. I have gotten into trouble with the school administration because of behavior resulting from drinking too much.

83. I have had trouble with the law because of drinking.

84. I have lost a job because of drinking.

85. I was involved in some type of accident after drinking.

86. I did not remember what happened while I was drinking.

87. I have done something after drinking which I later regretted.

SECTION VIII

TO BE COMPLETED BY STUDENTS WHO INDICATED ANSWER "a" OR "b" (THEY ARE NON-DRINKERS) ON QUESTION #11.

Which, if any, of the following reasons influence you to refrain from consuming alcohol?

88. Not of legal age to drink. a. Yes b. No

89. Do not like the taste. a. Yes b. No

90. Do not enjoy the physical effects. a. Yes b. No

91. Parents' disapproval. a. Yes b. No

92. Friends' disapproval. a. Yes b. No

93. Moral or religious reasons. a. Yes b. No

94. Can't afford it. a. Yes b. No

95. Lose control when I drink. a. Yes b. No

96. Other (specify)

97. Since you don't drink, do you feel hesitant about attending social functions where alcoholic beverages are served? a. Yes b. No

98. Do you believe that people who drink tend to have a lower opinion of people who do not drink? a. Yes b. No c. Don't know

99. Do you believe that people who do not drink tend to have a lower opinion of people who do drink? a. Yes b. No c. Don't know

100. Do you think there are enough adequate, healthy alternatives to drinking-oriented activities on this campus? a. Yes b. No c. Not sure

APPENDIX J
PARENTAL ALCOHOLISM INFORMATION SURVEY

Instructions: Please circle the letter corresponding to the correct answer. If a written response is called for, then please answer in the space provided. Thanks for your help.

SECTION I

1. Age:

2. Sex: a. female b. male

3. Race: a. Caucasian b. Black c. Hispanic d. Oriental e. American Indian f. Other (please specify):_____

4. What is your marital status? a. single b. married c. separated d. divorced e. widowed

5. Religious preference: a. Protestant b. Jewish c. Catholic d. Other (please specify):_____

6. What is your school classification: a. freshman b. sophomore c. junior d. senior e. graduate student

7. Place of residence: a. university housing b. fraternity house c. sorority house d. off campus housing e. parent's home

8. How many brothers do you have? _____ Ages:_____

9. How many sisters do you have? _____ Ages:_____

10. Which of your parents is (was) an alcoholic? a. father b. mother c. both d. other (ex. step-parent) (please specify):_____

If you have answered "c. both," please respond to questions 11-15 for each parent, using MO (mother, FA (father) as abbreviations.

11. How long have you lived with your alcoholic parents since their drinking first became a problem?_____
_____

12. Does your alcoholic parent acknowledge his/her alcoholism?
    a. Yes b. No

13. Has your alcoholic parent ever belonged to Alcoholics Anonymous (AA) or received treatment for their drinking problem?
    a. Yes b. No

14. Is he/she currently a member of AA or receiving treatment of some kind? a. Yes b. No (If "Yes," please explain briefly):_____
    _____

15. What is the current status of your parent's illness?
    a. actively drinking b. process of recovery

16. Have you ever attended an "open" meeting of Alcoholics Anonymous? a. Yes b. No (If "Yes," how many times):
    _____

17. Do you know what Al-Anon is? a. Yes b. No

18. Have you ever attended an Al-Anon meeting? a. Yes b. No (If "Yes," how many times):_____

19. Do you know what Alateen is? a. Yes b. No

20. Have you ever attended an Alateen meeting? a. Yes b. No (If "Yes," how many times):_____

21. Have you ever taken the course offered at the University of Florida on alcohol use and abuse or a course on alcohol education elsewhere? a. Yes b. No

SECTION II

In this section there are some questions about alcoholism and its effects on family members. The answers are either true or false. If you do not know the answer to a question, please DO NOT GUESS. Instead, circle the letter corresponding to don't know.

22. Alcoholism is a very treatable illness, because 2/3 or more of all alcoholic people can be treated successfully.

    a. True b. False c. Don't know

23. Alcoholics typically deny that they have a drinking problem, thereby enabling the disease of alcoholism to progress.

    a. True b. False c. Don't know

24. Nonalcoholic family members often feel that need to protect themselves from the pain of facing reality by refusing to admit that there is a drinking problem within their family.

    a. True b. False c. Don't know

25. Protecting alcoholics from fully experiencing the painful results of their drinking enables them to continue denying their lack of control and need for help.

    a. True b. False c. Don't know

26. Alcoholics frequently blame close family members for causing them to drink, because alcoholics find it difficult to accept responsibility for their drinking problem.

    a. True b. False c. Don't know

27. Lack of social norms of standards for what constitutes the responsible use of alcohol makes it easy for people to deny the existence of a drinking problem.

    a. True b. False c. Don't know

28. The children of alcoholics are approximately twice as likely to become alcoholic as the children of nonalcoholic parents.

    a. True b. False c. Don't know

29. A minimum of 1/3 of the offspring of alcoholic parents can expect to abuse alcohol as adults.

    a. True b. False c. Don't know

30. The degree of a child's vulnerability to emotional damage usually has little to do with how old the child is when the parent begins to encounter problems with their drinking.

    a. True b. False c. Don't know

31. Seriousness of the parent's alcoholism has less effect on whether the child will become alcoholic than does the length of exposure to the alcoholic parent.

    a. True b. False c. Don't know

32. Some students with alcoholic parents appear to be more self-sufficient and to achieve greater success than their peers just because of what they have experienced at home.

    a. True b. False c. Don't know

33. In addition to being a population at risk for developing alcoholism, children of alcoholics have a greater than average chance of encountering social and/or psychological difficulties later in life.

34. The offspring of alcoholics have more ways of coping with emotional upset than do the children of nonalcoholics.

    a. True b. False c. Don't know

35. Those children who grew up in an alcoholic family and seem to be doing fine are likely to have little or no difficulty adapting to adult life.

    a. True b. False c. Don't know

36. It is not until after they have begun to lead settled lives as adults that many seemingly well-adjusted children of alcoholics first become aware of social and/or psychological problems related to their alcoholic parentage.

    a. True b. False c. Don't know

37. It is fairly common for children to feel more affection for the alcoholic than for the nonalcoholic parent.

    a. True b. False c. Don't know

38. Family members who try to help the alcoholic without a good understanding of the disease are called "co-alcoholics," because their efforts to help almost always make matters worse.

    a. True b. False c. Don't know

39. Alcoholism is a "family disease" that adversely affects all of the family, and recovery from alcoholism involves healing the emotional illness of all family members.

    a. True b. False c. Don't know

40. If the alcoholic parent stops drinking, then family life will soon become significantly better.

    a. True b. False c. Don't know

41. When family members are helped to change themselves, at least 50% of their alcoholics recover as well.

    a. True b. False c. Don't know

42. For best therapeutic results, children of alcoholics are advised to combine Alateen (for 13-20 years old) or Al-Anon (if over 20) with individual, group,or family counseling.

    a. True b. False c. Don't know

43. Paternal rather than maternal alcoholism generally has more serious consequences for the children.

    a. True b. False c. Don't know

44. Girls who grow up in a home with alcoholic fathers rarely marry men with a serious drinking problem.

    a. True b. False c. Don't know

45. Efforts to control the alcoholic's drinking are doomed to failure because alcoholism is a disease that cannot be arrested by treatment until the alcoholic will admit to having a problem and needing help.

    a. True b. False c. Don't know

46. By involving themselves in a critical or controlling manner, family members force the alcoholic to assume responsibility for their behavior and its consequences.

    a. True b. False c. Don't know

SECTION III

The statements that follow refer to ways of reacting to parental alcoholism. Please think carefully about each one and then circle the letter corresponding to how likely to are to act that way: a. very likely (VL), b. likely (L) c. somewhat likely (SL), d. unlikely (U) e. very unlikely (VU)

How likely are you to:

47. Feel that the first responsibility of spouse and children is to themselves, because there is nothing they can do to force the alcoholic to stop drinking.

    a. VL b. L c. SL d. U e. VU

48. Emotionally detach yourself from your parent's drinking and the problems at home (while still loving them).

    a. VL b. L c. SL d. U e. VU

49. Feel frustrated by the alcoholic's behavior and their inability to control it.

    a. VL b. L c. SL d. U e. VU

50. Resent your alcoholic parent's drinking.

    a. VL b. L c. SL d. U e. VU

51. Respect your alcoholic parent when they are sober.

    a. VL b. L c. SL d. U e. VU

52. Be hesitant about making new friends or letting people know what you are really like for fear that they won't like you when they find out about your alcoholic parent.

    a. VL b. L c. SL d. U e. VU

53. Hold your alcoholic parent responsible for having the disease of alcoholism.

    a. VL b. L c. SL d. U e. VU

54. Feel guilty because of anger or other negative feelings toward one or both of your parents.

    a. VL b. L c. SL d. U e. VU

55. Feel that alcoholics hate themselves for not being able to control or stop their drinking.

    a. VL b. L c. SL d. U e. VU

56. Respect your nonalcoholic parent.

    a. VL b. L c. SL d. U e. VU

57. Feel that your parent would not drink if they really loved you.

    a. VL b. L c. SL d. U e. VU

58. Feel that if you were a better son or daughter, then your parent would not drink.

    a. VL b. L c. SL d. U e. VU

59. Hold yourself capable of and responsible for curing the alcoholism.

    a. VL b. L c. SL d. U e. VU

60. Take the fruit of your experiences -- the tough things you saw as well as the positive and constructive experiences -- and build them into the kind of life you want for yourself.

    a. VL b. L c. SL d. U e. VU

61. Feel ashamed about having an alcoholic parent.

    a. VL b. L c. SL d. U e. VU

62. Think seriously about how you have been affected by your parent's alcoholism.

    a. VL b. L c. SL d. U e. VU

63. Admit to yourself that you have developed both strengths and weaknesses as a result of whatever role(s) you have to adopt in order to survive the experience of living with an alcoholic parent.

    a. VL b. L c. SL d. U e. VU

64. Be willing, as the offspring of an alcoholic, to accept the role of one who might need help.

a. VL b. L c. SL d. U e. VU

65. Decide that it represents an act of love and concern on your part to let your alcoholic parent experience the consequences of their drinking.

a. VL b. L c. SL d. U e. VU

66. Believe that by helping yourself, you are thereby better able to help your alcoholic parent.

a. VL b. L c. SL d. U e. VU

SECTION IV

To the best of your recollection, indicate the extent to which you have engaged in the following behaviors during the past 2 MONTHS. Circle the letter that corresponds to the correct number of times: a. never, b. once, c. twice, d. 3 times, e. 4 times or more.

67. I have hidden my parent's drinking problem from others and pretended that it did not exist.

a. never b. once c. twice d. 3 times e. 4 times or more

68. I have discussed my worries about my alcoholic parent with a knowledgeable person outside the family.

a. never b. once c. twice d. 3 times e. 4 times or more

69. I have sought professional counseling when I felt the drinking problem at home might be affecting my personal life.

a. never b. once c. twice d. 3 times e. 4 times or more

70. I have attended an "open" Alcoholics Anonymous meeting.

a. never b. once c. twice d. 3 times e. 4 times or more

71. I have attended an Alateen or Al-Anon meeting.

a. never b. once c. twice d. 3 times e. 4 times or more

72. I have encouraged a nonalcoholic family member to attend an Alateen or Al-Anon meeting.

a. never b. once c. twice d. 3 times e. 4 times or more

73. I have provided other family members with helpful reading materials about the disease of alcoholism and its effects on the family.

a. never b. once c. twice d. 3 times e. 4 times or more

74. I have expressed faith in my alcoholic parent's ability to recover by showing support and/or giving sincere compliments.

a. never b. once c. twice d. 3 times e. 4 times or more

75. I have alerted my siblings to their high risk level and tried to help them make informed choices about how to deal with these risks.

a. never b. once c. twice d. 3 times e. 4 times or more

76. I have closely monitored the physical and psychological effects of alcohol on myself when I drink.

a. never b. once c. twice d. 3 times e. 4 times or more

77. I have had trouble concentrating on school work due to worrying about my parent's drinking problem.

a. never b. once c. twice d. 3 times e. 4 times or more

78. I have, in a fit of temper, said or done things to my alcoholic parent that I did not want to (but could not help myself).

a. never b. once c. twice d. 3 times e. 4 times or more

79. I have shared my feelings and concerns about my parent's drinking problem with a close friend I can trust.

a. never b. once c. twice d. 3 times e. 4 times or more

80. I have resorted to drinking to solve a problem or because the day did not go right.

a. never b. once c. twice d. 3 times e. 4 times or more

If your alcoholic parent is in the midst of the recovery process and no longer actively drinking, then please skip the final six statements. Otherwise, respond in the same manner as before to the behaviors described.

81. I have let my alcoholic parent know that help is available and that I want to help them get it.

a. never b. once c. twice d. 3 times e. 4 times or more

82. I have gotten involved in a confrontation with my parent while they were drinking.

a. never b. once c. twice d. 3 times e. 4 times or more

83. I have nagged, preached, coaxed, or lectured my parent about their drinking.

a. never b. once c. twice d. 3 times e. 4 times or more

84. I have berated or humiliated my parent because of their drinking.

a. never b. once c. twice d. 3 times e. 4 times or more

85. I have thrown out or hidden my parent's supply of alcohol.

a. never b. once c. twice d. 3 times e. 4 times or more

86. I have gotten into a discussion with my parent about whether they are an alcoholic or not.

a. never b. once c. twice d. 3 times e. 4 times or more

APPENDIX K
FIRST COVER LETTER

Dear

Last quarter you volunteered to participate in a research study of educational group counseling for students with one or more alcoholic parent. You were asked to fill out two questionnaires, and your help in carefully filling them out was greatly appreciated. I need to ask for your assistance one final time in order to complete the research. I would appreciate it very much if you would fill out the enclosed questionnaires and return them to me in the enclosed self-addressed stamped envelope.

Again, your answers will be strictly confidential and used for research purposes only. Your anonymity will be protected, and no attempt will be made to identify individual questionnaires. However, you are asked to write the last four digits of your Social Security number in the upper right-hand corner of each questionnaire; this number will be used for matching purposes.

Please complete these questionnaires promptly (as soon as possible) and return them to me by _____ so that the research may be completed.

The results of this study will be available to you upon request at the end of the Fall quarter.

Thank you for your cooperation.

Sincerely,

Happy Klinefelter

APPENDIX L
FOLLOW-UP COVER LETTER

Dear

This is a follow-up to my previous letter and a reminder to please fill out the enclosed questionnaires and return them to me as soon as possible by stamped, self-addressed envelope if you have not already done so. I cannot emphasize enough the importance of your responding promptly. The research cannot be completed without a sufficient return of the questionnaires mailed out. A little bit of time on your part is all that is required for you to make a significant contribution to the cause of helping discover ways to assist university students with an alcoholic parent.

A lot of time and expense has gone into this project, and your cooperation is essential to its success. As I mentioned before, your responses will be kept strictly confidential and will be used for research purposes only. To make it possible to match questionnaires, you are asked to please write the last four digits of your Social Security number in the upper right-hand corner of each questionnaire.

Thank you very much for your help with this. If you have already mailed the completed questionnaires sent to you earlier, then please disregard this request.

Sincerely,

Happy Klinefelter

APPENDIX M
RESPONSIBLE DRINKING PARTY*

This activity requires a lot of planning and a small financial investment, but it can be a tremendously valuable learning experience. The idea is to provide an opportunity for students to actually experience being a good host and/or a responsible drinker. This type of acquired knowledge will stay with a person.

Planning. Allow the students to plan the party with your guidance. If tax deductible donations can be solicited from liquor retailers, expenses will be minimal. Otherwise, all material needs can be met by having everyone bring something. Students are usually very eager to participate. It can be a lot of fun as well as a meaningful learning experience. Whenever possible, try to procure the use of a breath analyzer from the police or sheriff's department.

Things to consider:

Type and amount of alcoholic beverages
Soft drinks, juices, punch, mixers
Food -- munchies, meats, cheeses
Location -- sufficient room and seating, recreational equipment, easy access
Activities -- planned non-drinking games and activities
Transportation -- ways to get home without driving, volunteer drivers
Calculation of BAC -- breath analyzer, BAC chart or calculator
Time Limits -- starting and stopping serving of alcohol
Guests -- who, how many
Incidentals -- size of cups, ice, plates a napkins, name tags, etc.

Suggestions for a good party:

Plan for a time when students would normally be going out or having this class.
Distribute responsible drinking pamphlets and materials.
Provide samples of beer, wine and liquor for comparison.
Label the alcohol content of all beverages so individuals can compute their own BAC.
Be sure to have a clearly visible clock to monitor drinking time and rate.

Have all participants, especially drivers, take breath tests before leaving.
Record party on videotape, take photos, or invite a reporter.
Have guests write something on paper or speak into a tape recorder before, during and after drinking. The results can be very enlightening.
Administer road side intoxication test to drivers.
Serve non-alcoholic punch but tell drinkers it is spiked: see how many start to feel the effects.
Have bartenders record number and type of drinks for each guest.

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*From: Rozelle, G. & Gonzalez, G. Peer Group Facilitator Training Manual, University of Florida, 1977

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BIOGRAPHICAL SKETCH

Harry Fitch Klinefelter, III, was born on August 29, 1948, in Baltimore, Maryland. He is the son of Dr. Harry F. Klinefelter, Jr., and the late Elaine W. Prosser and the brother of Susan K. Hummel and Stanard T. Klinefelter. Harry ("Happy") graduated from the Gilman School in Baltimore in 1966 and then went on to obtain a B.A. in political science at the University of Pennsylvania in 1970. Having competed for four years on the high school tennis team and played on Penn's lacrosse team, he continued his interest in sports by teaching and coaching tennis in Baltimore for the next six years. He then moved to Florida and received a M.Ed. in guidance and counseling at Florida Atlantic University in 1977. While at the University of Florida pursuing the degree of Doctor of Philosophy in counseling psychology, he became interested in research dealing with the prevention of alcohol abuse.

He is currently in the midst of serving a one-year internship at the Counseling-Psychological Services at the University of Texas, Austin. Following graduation in August, 1982, Mr. Klinefelter plans to work in a university counseling center and pursue his strong interest in working with children of alcoholics and the prevention of alcohol abuse.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Paul J. Wittmer
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Benjamin Barger
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Gerardo M. Gonzalez
Assistant Professor of
Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Dorothy D. Nevill
Associate Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Robert C. Ziller
Professor of Psychology

This dissertation was submitted to the Graduate Faculty of the Department of Counselor Education in the College of Education and to the Graduate Council, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

August, 1982

Dean for Graduate Studies
and Research